

County of Los Angeles DEPARTMENT OF CHILDREN AND FAMILY SERVICES

425 Shatto Place, Los Angeles, California 90020 (213) 351-5602

Board of Supervisors
GLORIA MOLINA
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MARK RIDLEY-THOMAS
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MICHAEL D. ANTONOVICH
Fifth District

DOD: 05-24-2013

Emergency Response Referral

May 28, 2013 May 23, 2013 March 26, 2013 October 30, 2012

Emergency Response Notice of Referral Disposition

May 23, 2013 March 26, 2013 October 30, 2012

SDM Safety Assessment

May 23, 2013 April 15, 2013 November 1, 2012 April 21, 2011 March 21, 2007

SDM Risk Assessment

May 23, 2013 (a) May 23, 2013 (b) December 28, 2012 June 8, 2011

Medical Records

Total Pages Excluding Index: 120 pages

		-					
NAME OF Department of Departme	artment of Children	and Family Se	rvices Bur	eau of Child Pro	tection	DATE:	05/28/2013
STREET ADDRESS: 1933	3 S. Broadway Blvd.,	5th Floor					
CITY AND ZIP CODE : Los	Angeles, California	90007		COUNTY: Los An	geles		
NAME OF SOCIAL WORKER:			CASELOAD	ID :		TELEPHONE	
						(213) 639-45	500
	EMERGENC	Y RESPONS	SE REFE	RRAL INFOR	MATION		- 1
REFERRAL NAME:	-E0			REFERRAL NUMBE	R:		
y EVALUATE	IMMEDIATE	3 DAY	5 DAY	10 DAY	N/A SEC	ONDARY	
A OUT	IIVIIVIEDIATE] SDAT	JOHN	I TO DAT	L REPORT		
		SCREENE	R INFORM	IATION			
NAME			TITLE CSW II		DAT	E /28/2013	TIME 03:51pm
CASELOAD#		PHONE NUMBER		LOCATIO		20/2013	03.31pm
5.15225.15.11		(213) 639	-4500	Child	l Protection	on Hotline	(CPH)
ALERTS:	DODE /MEDIA ALEDE						
CHILD FATALITY REF				death was prev	ziously re	norted in	
Evaluate Out: The	IR-Palmdale (ERC						ferral
#	dated 05/	23/13 which	current	cly remains un	nder inves	tigation t	o ERCP
CSW		213) 639-450		cry romarno a	1401 111100		
		*					
1 referral under :	investigation da	ted 03/26/2	2013, ass	signed to Palm	ndale Offi	ce, CSW	
, file							
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Open Emergency Res		olving	and	ass	signed to	Palmdale (Dilice,
CSW	, file						
Due to the nature	of the incident	reported.	CWS/CMS	reflects the	family as	'sensiti	ve'.
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CURRENT LOCATION OF CHILI	D(REN)						
(decease	ed) body is curr		ne Los A	ngeles Depart	ment of Co	roner: 110	04 N
Mission Rd, Los A	ngeles, CA 90033						
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The children	and	are curre	ently co	nfidentially p	placed in	the loster	r nome or
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VICTIM INFORMATION	
NAME AKA (if applicable)	SOCIAL SECURIT
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8 Year(s) M	ICWA ELIGIBILITY

Emotional Abuse Emotional Abuse Physical Abuse Physical Abuse Severe Neglect

CASE WORKER NAME (FOR OPEN CASE)

CHILD(RENS) NAME (S)

PHONE # (FOR OPEN CASE)

CASELOAD#

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SCHOOL/DATCARE	ADDRESS					
ABUSE CATEGORY	(See Screen	ner Narrative Attach	ned)	ALLEGED PERPETRA	TOR NAME	
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ADDRESS					
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	CR	OSS REPORT INFORMAT	TION		The state of the s
AGENCY		L CONTACTED		TITLE	
Palmdale LASD					
ADDRESS			PHONE NUMBE	R	BADGE NO.
Palmdale LASD					
750 East Avenue Q					4.0
Palmdale, Californi	a 93550				
CROSS REPORTED BY				DATE & TIME	OF REPORT
CROSS REPORTED BY				05/28/20	
				03/20/20	113 03.27pm
DECEDBAL ID	CLIENT NAME	REFERRAL HISTORY	I per	ERRAL ROLE	I DECEDBAL DATE
REFERRAL ID	CLIENT NAME			tim	02/26/2007
ALLEGATION TYPE		ALLEGATION DISPOSITION		CIN	02/20/200
Emotional Abuse		Unfounded			
General Neglect		Unfounded			
100.000		REFERRAL HISTORY			
REFERRAL ID	CLIENT NAME	NEI ERIOLE IIIO I OITI	REFE	RRAL ROLE	REFERRAL DATE
			Vic	tim	04/13/2013
ALLEGATION TYPE		ALLEGATION DISPOSITION	ON		*
At Risk, sibling ab	oused	Unfounded			
and the state of the same					
		REFERRAL HISTORY			
REFERRAL ID	CLIENT NAME			RRAL ROLE	REFERRAL DATE
ALLEGATION TYPE		ALLEGATION DISPOSITION		tim	11/22/2004
At Risk, sibling ab	nised	Unfounded	ON		
iii iiiii, baaaaa aa					
		REFERRAL HISTORY			
REFERRAL ID	CLIENT NAME	REFERRAL HISTORY	REFE	RRAL ROLE	REFERRAL DATE
THE ENGLES	OLILITY TO MILE			tim	02/26/2007
ALLEGATION TYPE		ALLEGATION DISPOSITION			
Emotional Abuse		Unfounded			
	V 1 (5) (2) (9)	REFERRAL HISTORY			
REFERRAL ID	CLIENT NAME		/67233333	RRAL ROLE	REFERRAL DATE
				tim	05/23/2013
ALLEGATION TYPE		ALLEGATION DISPOSITION	ON		
Caretaker Absence/I		Substantiated Substantiated			
Caretaker Absence/I Emotional Abuse	леарастсу	Substantiated			
Emotional Abuse		Substantiated			
At Risk, sibling ab	nised	Substantiated			
we wisk, siniting an	, useu	Substantiated			
		BEEEEE!! !!!			
DESERBRAL ID	Louisus	REFERRAL HISTORY	T ====	DDAL DC: 5	
REFERRAL ID	CLIENT NAME			ERRAL ROLE	REFERRAL DATE
			ATC	- LILL	11/22/2004

Physical Abuse

Unfounded

123/11		REFERRAL HISTORY		
REFERRAL ID	CLIENT NAME		REFERRAL ROLE	REFERRAL DATE
		ALLEGATION DISPOSITION	Victim	10/30/2012
ALLEGATION TYPE Physical Abuse		Inconclusive		
At Risk, sibling abo	nsed	Substantiated		
At RISK, Sibiling abo	useu	Substantiacea		100
	COLOR DISTRIBUTE	REFERRAL HISTORY		7.66
REFERRAL ID	CLIENT NAME	KEI EKKAE IIIOTOKI	REFERRAL ROLE	REFERRAL DATE
	_		Victim	08/21/2003
ALLEGATION TYPE		ALLEGATION DISPOSITION		
Severe Neglect		Unfounded		
Severe Neglect		Unfounded		
		DESERBAL HISTORY		
REFERRAL ID	CLIENT NAME	REFERRAL HISTORY	REFERRAL ROLE	REFERRAL DATE
REFERRAL ID	CEIENTINAME		Victim	02/26/2007
ALLEGATION TYPE		ALLEGATION DISPOSITION		
Emotional Abuse	K - 18 *	Unfounded		
		Allert Allert		
		REFERRAL HISTORY	L DESERBAL BOLE	REFERRAL DATE
REFERRAL ID	CLIENT NAME		REFERRAL ROLE Victim	03/26/2013
ALLEGATION TYPE		ALLEGATION DISPOSITION	VICCIII	03/20/2013
At Risk, sibling ab	used	ALLEGATION DIGITION		
At Risk, sibling ab				
The fitting of				f Paris
		REFERRAL HISTORY		
REFERRAL ID	CLIENT NAME	TEL ERIOLE HIGHORY	REFERRAL ROLE	REFERRAL DATE
			Victim	04/13/2011
ALLEGATION TYPE		ALLEGATION DISPOSITION		
General Neglect		Unfounded		
	The state of the state of			
REFERRAL ID	CLIENT NAME	REFERRAL HISTORY	REFERRAL ROLE	REFERRAL DATE
REFERRALID	CEIENT NAME		Victim	05/23/2013
ALLEGATION TYPE		ALLEGATION DISPOSITION		
Caretaker Absence/I	ncapacity	Substantiated		
Caretaker Absence/I		Substantiated		
Emotional Abuse		Substantiated		
Emotional Abuse		Substantiated		
Physical Abuse		Substantiated		
Physical Abuse		Substantiated		
Physical Abuse	4 4 4 4 4 4	Substantiated		
Charles and Control			8-1	
	to State	REFERRAL HISTORY	L personal police	DESCRIPTION DATE
REFERRAL ID	CLIENT NAME		REFERRAL ROLE Victim	10/30/2012
ALLEGATION TYPE		ALLEGATION DISPOSITION	1 2 C LIN	
General Neglect		Substantiated		
Physical Abuse		Inconclusive		

		REFERRAL HISTORY		
REFERRAL ID	CLIENT NAME		REFERRAL ROLE	REFERRAL DATE
W. FOATION TYPE		ALLEGATION DISPOSITION	Victim	02/26/2007
ALLEGATION TYPE Emotional Abuse		Unfounded		
Dinoctorial Traces				
		REFERRAL HISTORY		
REFERRAL ID	CLIENT NAME	REFERRAL HISTORY	REFERRAL ROLE	REFERRAL DATE
NEI ENIVE ID	OLIZIT! !!		Victim	03/26/2013
ALLEGATION TYPE		ALLEGATION DISPOSITION		
Sexual Abuse				
Sexual Abuse				
		REFERRAL HISTORY		
REFERRAL ID	CLIENT NAME		REFERRAL ROLE	REFERRAL DATE
ALLEGATION TYPE		I ALLEGATION DISPOSITION	Victim	04/13/2011
At Risk, sibling ak	nused	Unfounded		
At Misk, Sibiling at	74564			
		DEFENDAL HISTORY		
DECEDRAL ID	CLIENT NAME	REFERRAL HISTORY	REFERRAL ROLE	REFERRAL DATE
REFERRAL ID	CLIENT NAME		Victim	05/23/2013
ALLEGATION TYPE		ALLEGATION DISPOSITION	70, 402, 7, 404,	
Caretaker Absence/1		Substantiated		
Caretaker Absence/	Incapacity	Substantiated		
Emotional Abuse		Substantiated		
Emotional Abuse	varceress•	Substantiated		
At Risk, sibling ak	oused	Substantiated		
		REFERRAL HISTORY		
REFERRAL ID	CLIENT NAME		REFERRAL ROLE Victim	REFERRAL DATE 11/22/2004
ALLEGATION TYPE		ALLEGATION DISPOSITION	VICCIM	11/22/2004
At Risk, sibling ak	oused	Unfounded		
			10.4.1	
		REFERRAL HISTORY		
REFERRAL ID	CLIENT NAME	KEI EKKAL HISTOKT	REFERRAL ROLE	REFERRAL DATE
NEI ENIOL ID	OEIEITT TO UNE		Victim	10/30/2012
ALLEGATION TYPE		ALLEGATION DISPOSITION		
At Risk, sibling al	oused	Substantiated		
	a settle an artificial			
		REFERRAL HISTORY		
REFERRAL ID	CLIENT NAME		REFERRAL ROLE	REFERRAL DATE
		ALLEGATION DISPOSITION	Victim	08/21/2003
ALLEGATION TYPE Substantial Risk		Unfounded		
Substantial Risk		Unfounded		
		DECEDRAL LISTORY		
REFERRAL ID	CLIENT NAME	REFERRAL HISTORY	REFERRAL ROLE	REFERRAL DATE
NEFERINAL IU	OFICIAL IAVINE		Victim	02/26/2007
ALLEGATION TYPE	6.7	ALLEGATION DISPOSITION		
Emotional Abuse		Unfounded		
Physical Abuse		Unfounded		

		REFERRAL HISTORY		
REFERRAL ID	CLIENT NAME	7271	REFERRAL ROLE	REFERRAL DATE
			Victim	03/26/2013
ALLEGATION TYPE		ALLEGATION DISPOSITION		
At Risk, sibling abused				
At Risk, sibling abused				100 200
	In the second			4,430
		REFERRAL HISTORY		
REFERRAL ID	CLIENT NAME		REFERRAL ROLE	REFERRAL DATE
		ALLEGATION DISPOSITION	Victim	04/13/2011
ALLEGATION TYPE At Risk, sibling abused		Unfounded		
At Risk, Sibiling abused		Ulifounded		
		REFERRAL HISTORY		
REFERRAL ID	CLIENT NAME		REFERRAL ROLE	REFERRAL DATE
		LANGE ATION DISPOSITION	Perpetrator	05/23/2013
ALLEGATION TYPE	201+11	ALLEGATION DISPOSITION Substantiated		
Caretaker Absence/Incapa		Substantiated		
Caretaker Absence/Incapa				
Caretaker Absence/Incapa	acity	Substantiated		
Emotional Abuse		Substantiated		
Emotional Abuse		Substantiated		
Emotional Abuse		Substantiated		
Physical Abuse	100	Substantiated		
		REFERRAL HISTORY		
REFERRAL ID	CLIENT NAME		REFERRAL ROLE	REFERRAL DATE
			Perpetrator	11/22/2004
ALLEGATION TYPE		ALLEGATION DISPOSITION		(482)
Physical Abuse		Unfounded		
At Risk, sibling abused		Unfounded	2.1	
	The same street			
		REFERRAL HISTORY		
REFERRAL ID	CLIENT NAME		REFERRAL ROLE	REFERRAL DATE
			Perpetrator	10/30/2012
ALLEGATION TYPE	4,777	ALLEGATION DISPOSITION		
General Neglect		Substantiated		
Physical Abuse		Inconclusive		
Physical Abuse		Inconclusive		
At Risk, sibling abused		Substantiated		
At Risk, sibling abused		Substantiated		
		REFERRAL HISTORY		7
REFERRAL ID	CLIENT NAME		REFERRAL ROLE	REFERRAL DATE
ALL FOATION TYPE		ALLEGATION SUSPECTION	Perpetrator	02/16/2007
ALLEGATION TYPE		ALLEGATION DISPOSITION Unfounded		
Physical Abuse		Ulifoulided		

Physical Abuse Substantial Risk

Inconclusive

REFERRAL HISTORY					
REFERRAL ID	CLIENT NAME		REFERRAL ROLE Perpetrator	08/21/2003	
ALLEGATION TYPE Severe Neglect	1	ALLEGATION DISPOSITION Unfounded			
Substantial Risk		Unfounded	100		

REFERRAL HISTORY					
REFERRAL ID	CLIENT NAME		REFERRAL ROLE Perpetrator	02/26/2007	
ALLEGATION TYPE		ALLEGATION DISPOSITION		•	
Emotional Abuse		Unfounded			
Emotional Abuse		Unfounded			
Emotional Abuse		Unfounded			
Emotional Abuse		Unfounded			
Emotional Abuse		Unfounded			
General Neglect		Unfounded			
Physical Abuse		Unfounded			

REFERRAL HISTORY					
REFERRAL ID CLIENT NAME		REFERRAL ROLE Perpetrator	04/13/2011		
ALLEGATION TYPE	ALLEGATION DISPOSITION				
General Neglect	Unfounded				
At Risk, sibling abused	Unfounded				
At Risk, sibling abused	Unfounded				
At Risk, sibling abused	Unfounded				

REFERRAL HISTORY						
REFERRAL ID	CLIENT NAME		REFERRAL ROLE Perpetrator	05/23/2013		
ALLEGATION TYPE		ALLEGATION DISPOSITION	*			
Emotional Abuse		Substantiated				
Emotional Abuse		Substantiated				
Emotional Abuse		Substantiated				
Physical Abuse		Substantiated				

		REPORTER INFORMAT		
ME		AGENCY OR ORGANIZATIO	N RELATIONSHIP	
DRESS			PRIMARY PHONE	
		,	SECONDARY PHONE	
NTACT DATE	CONTACT METHOD	DESCRIPTION		

Referral Number

Referral Date

05/28/2013

SCREENER NARRATIVE

ALLEGATIONS (Who, What, Where, When, How, Who Else Knows, Why Now?) COLLECT AND RECORD INFORMATION ABOUT THE FOLLOWING RISK FACTORS:

- PRECIPITATING INCIDENT (Severity, frequency; location and description of injury; history of abuse)
- CHILD CHARACTERISTICS (Age, vulnerability, special circumstances; perpetrator's access; behavior, interaction with 2. caretakers, sibling and peers)
- CARETAKER CHARACTERISTICS (Capacity for child care; interaction with children, other caretakers; skill, knowledge; substance abuse, criminal behavior, mental health)
- FAMILY FACTORS (Relationships, support systems; history of abuse; presence of parent substitute; environmental conditions; family strengths)
- DOMESTIC VIOLENCE/ABUSE FACTORS (Safety risks; pattern of assaults on, threats to, and/or stalking of household members; forced social isolation or economic deprivation; weapons present in the home and used as a threat; prior law enforcement or emergency medical response(s); history of domestic violence/abuse; medical neglect; violation of restraining orders; mental health issues; other risk factors)

CHILD FATALITY REPORT/MEDIA ALERT
This is a referral generated through an emailed report.
The incident precipitating death was previously reported in IR-Palmdale (ERCP), Critical Incident/Near Fatality/Media Alert referral # dated 05/23/13 which was cross reported to Palmdale Sheriff Station.
Due to the nature of the incident reported, CWS/CMS reflects the family as 'sensitive'.
Response Priority: Evaluate Out
Referral History:
1 referral identifying the incident precipitating death which currently remains under investigation to ERCP CSW file (213)639-4500.
1 referral under investigation dated 03/26/2013, assigned to Palmdale Office, CSW file
5 additional prior referrals – 2003-2012
1 additional referral identifying mother as a perpetrator – 2007
Case History:
State of California Health and Welfare Agency COPENED INCOPMATION Confidential in accordance with

Referral Date 05/28/2013

Open Emergency Response cases involving	and	assigned to Palmdale Office,
CSW , file ,		
		012-03/29/2013 and closed FM case
involving dated 11/01/2012-04/25/2013.		
Domestic Violence:		
None Known		
Mental Health Concerns:		
None Known		
Physical/Developmental/Other Disabilities:		
None Known		
Location of Incident:		
Home Address		
Alleged Perpetrators:		
mother	oer.	
no relation/mother's significant oth	iei	
Reporting Party:		
Collateral Contacts:		
Detective Detective		
LASD Homicide		

Referral Number:

Referral Date

05/28/2013

Report #
(323)890-5500
School/Location Information: (deceased) body is currently at the Los Angeles Department of Coroner: 1104 N Mission Rd, Los Angeles, CA 90033.
The children and are currently confidentially placed in the foster home of and
resides with her respective father at:
resides with paternal grandmother at:
Referred Children: (deceased), male 8 years female 10 years male 12 years
Report: contacted the Child Protection Hotline to report the death of 8 years.
The reporting party states is a battered child. On 5/23, was transported from his home to after police and paramedics responded to the home and found him to be unresponsive. was also noted to have external injuries. Upon arrival at was resuscitated and transferred to to receive a higher level of care and was admitted to the PICU. Reporting party states that condition did not improve and brain death was pronounced and findings were confirmed by Dr. and Dr. on 5/24 at 2:30pm. Cardiac death was pronounced on 5/25.
An autopsy is pending. Cause of death is yet to be determined. Apparent mode of death is homicide. The coroner case number is Reporting party states was found to have multiple external and internal injuries. Numerous injuries were documented, some of which include subdural hematomas, soft tissue swelling of the right parietal and bifrontal scalp soft tissue swelling, traumatic extraction of the upper central incisors, a rightward nasal septal deviation, diffuse circumferential soft tissue edema within the mid and lower neck, a metallic foreign body to the right lower lobe of the

Referral Number:

Referral Date 05/28/2013

lung and to the left inguinal area, acute right eighth and ninth posterior rib fractures, multiple bilateral healing rib fractures, a large laceration involving the liver, and poor contrast excretion from the kidnevs that was consistent with shock. LASD Homicide is investigating death. The police report number is Reporting party states mother and her significant other are currently in custody. This report reflects all pertinent information provided by the reporting party. NARRATIVE NOTES: LEADER and WCMIS search results have been attached to this report. Per the referral under investigation, 911 was called from the family's home and upon the arrival of law enforcement and paramedics, was discovered not breathing with marks all over face/body, possible burn marks, and BB gun (pellets) in his chest and groin. It was reported that mother's boyfriend admitted to punching in the abdomen on the day of his death, 10 times, and hit him on the back of the head with an open hand. It was also reported that a wash cloth was face and neck which resulted in torn skin to his forehead and below his neck. used to scrub Mother and her boyfriend admitted to committing this act. siblings reported that he and his 12 year old sibling were wrestling and chasing each other when fell, and hit his left temple on a table in the bedroom. Mother and her boyfriend were reported informed of what happened and placed in the shower to wake him up. mother was arrested on felony cruelty to a child charges unresponsive and 911 was called. (273(a)(a)) and currently remains incarcerated on \$1,003,300 bail. Mother's boyfriend is being charged, at minimum, with torture and attempted murder and currently remains incarcerated on \$1 million bail. 10 and 12 year old siblings were detained and are currently placed in foster care. 7 year old sibling resides with her respective father, who has sole legal and physical custody of her. Mother has not attempted contact with this child in over a year and there is court ordered monitored visitation that was established in 2007. 9 year old sibling resides in Texas with his paternal grandmother. This incident is receiving extensive media coverage in print and news outlets, which began on 5/23

and presently continues. DCFS is mentioned in the media stories.

NAME OF AGENCY:	Department of Children and F Post	amily Services Emergency	y Response Command	DATE: 05/23/2013
STREET ADDRESS :	1933 S. Broadway Blvd., 5th	Floor		
CITY AND ZIP CODE :	Los Angeles, California 9000	7 COUN	ITY: Los Angeles	
NAME OF SOCIAL WORKER	:	CASELOAD ID :		TELEPHONE
	Sec			(213) 639-4500
	EMERGENCY RE	SPONSE REFERRA	L INFORMATION	
REFERRAL NAME:	- IR	REFE	RRAL NUMBER:	
NA EVALUATE OUT	X IMMEDIATE 3 DAY	5 DAY	10 DAY N/A SE REPOR	CONDARY
1. + 1. % · ·	S	CREENER INFORMATIO		
NAME		TITLE CSW III		TIME 5/23/2013 02:24am
CASELOAD#		ONE NUMBER	LOCATION	5/25/2015 02.24dii
	(2	13) 639-4500	Child Protecti	ion Hotline (CPH)
ALERTS: NEAR FATALITY/ Mapped to Palm	CRITIAL INCIDENT/MEDIA dale office	ALERT		
ADDENDUM: This	report was additionall	y flagged as a Medi	a Alert on 5/23 (
Hotline).	TNOV		POLICE REPORT NUMBI	ED
LAW ENFORCEMENT AGE	ENCY		FOLICE REPORT NOMBI	LIN
		HOME ADDRESS		
		HOME ADDITION	PHONE N	IUMBER
	4 2			
	the state of the s			
ADDRESS COMMENTS	Verified using RAVS			
CURRENT LOCATION OF		_		
is at	will be transferred	to one of the	<u>.</u>	phone but it is not known
which one.	will be clansielled	to one of the	,	Date It It not mioni
The children		re at the LASD, Pal	.mdale station - 3	750 E. Avenue Q,
Palmdale 93550	, Deputy , #			
		VICTIM INFORMATION		
NAME		AKA (if applicable)		SOCIAL SECURITY #
200	ACE LACECODE LOEV LETIN	HOITY	LANGUAGE	ICWA ELIGIBILITY
DOB	AGE AGE CODE SEX ETHN 12 Year(s) M	IICITY	LANGUAGE	No
SCHOOL/DAYCARE NAM				
SCHOOL/DAYCARE ADDR	RESS			
The state of the s	Screener Narrative Attached)	ALLEGED PERPETRATOR NAME		
At Risk, sibli				
CASE WORKER NAME (F)	OR OPEN CASE)	PHONE # (FOR OPEN CASE)	CASELOAD#	

CHILD(RENS) NAME	(S)						CHILD I
roje Meliciji	. 20-						
1. 1717							
Andrews .	iki new						
					NFORMATION		SOCIAL SECURIT
AME	77 17	11 ² A		AKA (IT	applicable)		SOCIAL SECURIT
OB	AGE	AGE CODE	SEX	ETHNICITY		LANGUAGE	ICWA ELIGIBILITY
	8	Year(s)	М				No
CHOOL/DAYCARI	E NAME						
CHOOL/DAYCARI	E ADDRESS						
BUSE CATEGORY	Y (See Screen	ner Narrative Attacl	ned)	ALLEGED P	ERPETRATOR NAME		
hysical Al							
ASE WORKER NA	AME (FOR OPE	N CASE)	Ning	PHONE # (F	OR OPEN CASE)	CASELOAD#	
Section 1							
AME	Mark to				AFORMATION applicable)	2.24514	SOCIAL SECURITY
· IIII							
ОВ	AGE	AGE CODE	SEX	ETHNICITY		LANGUAGE	ICWA ELIGIBILITY
	10	Year(s)	F				No
CHOOL/DAYCAR	E NAME						
OU COLUDA VOAD	F 4000500						
CHOOL/DAYCAR	E ADDRESS						
		F 1					
BUSE CATEGOR	Y (See Screen	ner Narrative Attac	hed)	ALLEGED P	ERPETRATOR NAME		
t Risk, s							
ASE WORKER NA	AME (FOR OPE	N CASE)		PHONE # (F	OR OPEN CASE)	CASELOAD #	
ete , s		7 8 188		OTHERS	IN THE HOME		
AME					f applicable)		SOCIAL SECURIT
				1-11			
	TE OF BIRTH/	AGE	LANGUA	AGE		WORK	K PHONE
М			FORTO				
ROLE			FOR/TO				

No Relation No Relation No Relation

CASE WORKER NAME

CASELOAD #

PHONE #

		OTHERS IN THE HOM	ME		
NAME		AKA (if applicable)		soc	IAL SECURITY
SEX DATE OF BIRTH/AGE	LANGUAGE			WORK PHONE	
SEX DATE OF BIRTH/AGE	LANGUAGE			WORKTHONE	
ROLE	FOR/TO			L	
Mother (Birth)					
Mother (Birth)					
Mother (Birth)					1 0
CASE WORKER NAME		PHONE #	CASELOAD #		
SEX DATE OF BIRTH/AGE	LANGUAGE			WORK PHONE	
	. 15			WORK PHONE	
	LANGUAGE FOR/TO			WORK PHONE	
SEX DATE OF BIRTH/AGE ROLE ADDRESS	. 15			WORK PHONE PRIMARY PHONE	
ROLE	. 15				2
ROLE	. 15				
ROLE	. 15	DUONE 4	L CASELOAD #		
ROLE	. 15	PHONE #	CASELOAD#		
ROLE	. 15	PHONE #	CASELOAD#		
ROLE	. 15	PHONE #	CASELOAD#		
ROLE	. 15	PHONE #	CASELOAD#		

CONTACT METHOD

DESCRIPTION

ADDRESS

CONTACT DATE

CHILD(RENS) NAME (S)

PRIMARY PHONE

AGENCY	CROSS REPORT INFOR		TITLE	
Palmdale LASD				
ADDRESS	2 1 1	PHONE NUMBE	R	BADGE NO
Palmdale LASD				
750 East Avenue Q				1
Palmdale, California 93550				46.80
CROSS REPORTED BY			DATE & TIME OF RE	PORT
			05/23/2013	04:39am

		REFERRAL HISTORY		
REFERRAL ID	CLIENT NAME		REFERRAL ROLE	REFERRAL DATE
ALLEGATION TYPE		ALLEGATION DISPOSITION	Victim	11/22/2004
Physical Abuse		Unfounded		
	THE STATE OF	REFERRAL HISTORY	23.	
REFERRAL ID	CLIENT NAME		REFERRAL ROLE	REFERRAL DATE
			Victim	10/30/2012
ALLEGATION TYPE		ALLEGATION DISPOSITION Inconclusive		
Physical Abuse At Risk, sibling abused		Substantiated		
At Risk, Sibiling abused		Substantiated		
		REFERRAL HISTORY		
REFERRAL ID	CLIENT NAME	REPERRAL HISTORY	REFERRAL ROLE	REFERRAL DATE
			Victim	08/21/2003
ALLEGATION TYPE		ALLEGATION DISPOSITION		
Severe Neglect		Unfounded		
Severe Neglect		Unfounded		
		REFERRAL HISTORY		
REFERRAL ID	CLIENT NAME	REFERRAL HISTORY	REFERRAL ROLE	REFERRAL DATE
			Victim	02/26/2007
ALLEGATION TYPE	-	ALLEGATION DISPOSITION		
Emotional Abuse		Unfounded		
		DESERVATION AND A STATE OF THE		
REFERRAL ID	CLIENT NAME	REFERRAL HISTORY	REFERRAL ROLE	REFERRAL DATE
REFERIOLIB	OEIEIT ITAME		Victim	03/26/2013
ALLEGATION TYPE		ALLEGATION DISPOSITION		
At Risk, sibling abused				
At Risk, sibling abused				
		REFERRAL HISTORY		1 25552211 2175
REFERRAL ID	CLIENT NAME		REFERRAL ROLE Victim	04/13/2011
			VICCIM	04/15/2011
ALLEGATION TYPE		ALLEGATION DISPOSITION		

		REFERRAL HISTORY		
REFERRAL ID	CLIENT NAME		REFERRAL ROLE	REFERRAL DATE
ALLEGATION TYPE		ALLEGATION DISPOSITION	Victim	10/30/2012
General Neglect		Substantiated		
Physical Abuse		Inconclusive		
	State State State State St			
	-40 - 12 - 12 - 12	REFERRAL HISTORY		
REFERRAL ID	CLIENT NAME		REFERRAL ROLE	REFERRAL DATE
			Victim	02/26/2007
ALLEGATION TYPE		ALLEGATION DISPOSITION Unfounded		
Emotional Abuse		Ulifounded		
		REFERRAL HISTORY		
REFERRAL ID	CLIENT NAME	REFERRAL HISTORY	REFERRAL ROLE	REFERRAL DATE
NEI ENGLID			Victim	03/26/2013
ALLEGATION TYPE		ALLEGATION DISPOSITION		
Sexual Abuse				
Sexual Abuse				
		DESERBAL LUCTORY		
DESERBAL IN	LOUENTNAME	REFERRAL HISTORY	REFERRAL ROLE	REFERRAL DATE
REFERRAL ID	CLIENT NAME		Victim	04/13/2011
ALLEGATION TYPE		ALLEGATION DISPOSITION		
At Risk, sibling abu	sed	Unfounded		
			33.	
PERSONAL PROPERTY.		REFERRAL HISTORY		
REFERRAL ID	CLIENT NAME		REFERRAL ROLE	REFERRAL DATE
		ALLEGATION DISPOSITION	Victim	11/22/2004
ALLEGATION TYPE At Risk, sibling abu	sed	Unfounded		
At Kisk, Sibiling abu	seu	onrounded		
		REFERRAL HISTORY		
REFERRAL ID	CLIENT NAME	REPERRAL HISTORY	REFERRAL ROLE	REFERRAL DATE
	West of the American State of the State of t		Victim	10/30/2012
ALLEGATION TYPE		ALLEGATION DISPOSITION		
At Risk, sibling abu	sed	Substantiated		
REFERRAL ID	CLIENT NAME	REFERRAL HISTORY	REFERRAL ROLE	REFERRAL DATE
REFERRALID	CEIENT NAME		Victim	08/21/2003
ALLEGATION TYPE		ALLEGATION DISPOSITION		· •
Substantial Risk		Unfounded		
Substantial Risk		Unfounded		
	L OUENE WAYS	REFERRAL HISTORY	REFERRAL ROLE	REFERRAL DATE
REFERRAL ID	CLIENT NAME		Victim	02/26/2007
ALLEGATION TYPE		ALLEGATION DISPOSITION		-2/23/200/
Emotional Abuse		Unfounded		
Physical Abuse		Unfounded		

		REFERRAL HISTORY		
REFERRAL ID	CLIENT NAME		REFERRAL ROLE	REFERRAL DATE
			Victim	03/26/2013
ALLEGATION TYPE		ALLEGATION DISPOSITION		
At Risk, sibling abused		4.1		
At Risk, sibling abused				
		REFERRAL HISTORY		
REFERRAL ID	CLIENT NAME		REFERRAL ROLE	REFERRAL DATE
		ALLEGATION DISPOSITION	Victim	04/13/2011
ALLEGATION TYPE At Risk, sibling abused		Unfounded		
At Risk, Sibiling abused		onrounded		
		REFERRAL HISTORY		
REFERRAL ID	CLIENT NAME		REFERRAL ROLE	REFERRAL DATE 11/22/2004
ALLEGATION TYPE		ALLEGATION DISPOSITION	Perpetrator	11/22/2004
Physical Abuse		Unfounded		
At Risk, sibling abused		Unfounded		
At Kisk, Sibiling abasea		ozoaaoa		
100.0 100.0		REFERRAL HISTORY		
REFERRAL ID	CLIENT NAME		REFERRAL ROLE	REFERRAL DATE
			Perpetrator	10/30/2012
ALLEGATION TYPE		ALLEGATION DISPOSITION Substantiated		
General Neglect				
Physical Abuse		Inconclusive		
Physical Abuse		Inconclusive		
At Risk, sibling abused		Substantiated		
At Risk, sibling abused		Substantiated		
		REFERRAL HISTORY		
REFERRAL ID	CLIENT NAME		REFERRAL ROLE Perpetrator	02/16/2007
ALLEGATION TYPE		ALLEGATION DISPOSITION	respectator	02/10/2007
Physical Abuse		Unfounded		
Substantial Risk		Inconclusive		
Substantial Nisk		111001101401		
		REFERRAL HISTORY		
REFERRAL ID	CLIENT NAME		REFERRAL ROLE	REFERRAL DATE
			Perpetrator	08/21/2003
ALLEGATION TYPE		ALLEGATION DISPOSITION		
Severe Neglect		Unfounded		
Substantial Risk		Unfounded		

		REPORTER INFORMATION	
NAME		AGENCY OR ORGANIZATION	RELATIONSHIP
ADDRESS		·	PRIMARY PHONE
			SECONDARY PHONE
CONTACT DATE	CONTACT METHOD	DESCRIPTION	
CONTROLDATE	CONTINOT INCINOD	2233	
		The MANDATED DEPORTED	FAMILY INFORMED
	NYMOUS REPORTER	X MANDATED REPORTER	FAMILY INFORMED
ANO			
	LICATION FOR PETITION	CONFIDENTIALITY WAIVED	FEEDBACK REQUIRED

Referral Number:

Referral Date

05/23/2013

SCREENER NARRATIVE

ALLEGATIONS (Who, What, Where, When, How, Who Else Knows, Why Now?) COLLECT AND RECORD INFORMATION ABOUT THE FOLLOWING RISK FACTORS:

- PRECIPITATING INCIDENT (Severity, frequency; location and description of injury; history of abuse)
- CHILD CHARACTERISTICS (Age, vulnerability, special circumstances; perpetrator's access; behavior, interaction with caretakers, sibling and peers)
- CARETAKER CHARACTERISTICS (Capacity for child care; interaction with children, other caretakers; skill, knowledge; substance abuse, criminal behavior, mental health)
- FAMILY FACTORS (Relationships, support systems; history of abuse; presence of parent substitute; environmental conditions; family strengths)
- DOMESTIC VIOLENCE/ABUSE FACTORS (Safety risks; pattern of assaults on, threats to, and/or stalking of household members; forced social isolation or economic deprivation; weapons present in the home and used as a threat; prior law enforcement or emergency medical response(s); history of domestic violence/abuse; medical neglect; violation of restraining orders; mental health issues: other risk factors)

NEAR FATALITY/CRITICAL INCIDENT/MEDIA ALERT

EXPEDITED

LASD, Palmdale station Deputy Incident #

This Referral Is Generated From:

A live telephone call

Response Priority:

Immediate Response / Expedited

Prior DCFS/CPS History:

There are 7 prior referrals. A referral dated 3/26/13 is open to CSW Lancaster office, phone alleging sexual abuse.

Unfounded

10/30/12	Physical abuse	Inconclusive
10/30/12	General neglect	Substantiated
4/13/11	General neglect	Unfounded
2/26/07	Emotional abuse	Unfounded
2/26/07	Physical abuse	Unfounded
2/26/07	General neglect	Unfounded
2/16/07	Not this family but moth	ner is the perpetrator
11/22/04	Physical abuse	Unfounded

8/21/03

Severe neglect

Referral Number: 05/23/2013

Prior Family Maintenance Services were terminated for the child on 4/25/13 and for the children and on 3/29/13
Domestic Violence/Mental Health Issues/Substance Abuse/Gang Activity:
It is unknown if there is any history of domestic violence and substance abuse. The child has a history of self-mutilation. It is unknown if was ever admitted to a psychiatric hospital. There is no gang activity. There are no dogs or weapons, although has "bibis" lodged into his chest and groin.
Physical/Developmental/Other Disability: No
Child's Caregiver: The children reside with their mother and her boyfriend,
Incident Location:
Children's home
Dhana number net known
Phone number not known Phone number on LEADER:
Thore number on EEABER.
Perpetrator(s):
Unknown
Reporting Party: (Law Enforcement & DCFS representatives: Please DO NOT disclose Reporting Party & Collateral Contact's identity to the family being investigated):
Collateral Contacts:
Deputy (in charge of the case)

Referral Date 05/23/2013

Los Angeles County Sheriff's Department, Palmdale station	
750 E. Avenue Q	
Palmdale, 93550	
Phone (661) 272-2400	
Captain	
Los Angeles County Fire	
Engine #	
Palmdale station	
Address and phone number were not known	
School/Location Information:	
It is believed the children attend	, grades unknown
The child is at	
Discontinuity	
Phone	
The children and and are at:	
Los Angeles County Sheriff's Department, Palmdale station	
750 E. Avenue Q	
Palmdale, 93550	
Phone (661) 272-2400	
1 Hone (601) 272-2400	
Children Information:	
DOB: Male Age 8	
DOB: Female Age 10	
, DOB: Male Age 12	
Summary of Incident (Story):	
The child (age 8) is an alleged victim of physical abuse	by an unknown perpetrator. The
children (age 10) and (age 12) are at risk.	
Deputy stated that he does not have a lot of information by	out wanted to call DCFS to get
someone out to the station.	
	Confidential in accordance with

Referral Date 05/23/2013

Deputy stated that on 5/22/13 at approximately 11:45pm, he responded to the family's home.
Deputy stated that mother and siblings and reported the following story: and were in their room wrestling. was chasing who slipped, fell and hurt his head on his left temple area. went to get mother who called "911". was not breathing and the paramedics administered CPR.
Deputy stated that the paramedics reported that "there was something else going on." The paramedics reported that has numerous bruises on his body. has a "bibi" lodged "into his chest and one into his groin."
Deputy stated that mother reported that the bruises were from self-mutilation. Deputy stated that the "marks were not cuts, they were bruises," but the deputy could not describe them.
Deputy stated that Deputy would have more information as he is in charge of the case. The Special Victims Bureau is coming to investigate.
Deputy stated that is on life support at will be but it is unknown which one and when.
The children and are at the Palmdale Sheriff's station.
This referral reflects the information provided by the Caller.
Supplementary/additional questions to the reporting party: N/A
FOOTNOTE/ADDENDUM:
Info to CSW and email sent.
Expedited form sent to ERCP
LEADER report was requested to obtain demographic information
Print out of prior referral history, case history and family members attached.
ADDENDUM: This report was additionally flagged as a Media Alert on 5/23 (Leading, Hotline).

NAME OF AGENCY:	Department of Children and Family Services		DEPARTMENT/ DIVISION:	Emergency Response Command Pos
STREET ADDRESS:	1933 S. Broadway Blvd., 5th Floor			
CITY AND ZIP CODE:	Los Angeles, California 90007		COUNTY:	Los Angeles
	NAME OF SOCIAL WORKER		CASELOAD ID	TELEPHONE
				(213) 639-4500
	EMERGENCY RESPONSE	NOTICE O	F REFERRAL DI	SPOSITION
British State Service	NAME OF CHILD(REN)			CHILD ID NU
A Park Tild	e e e e e e e e e e e e e e e e e e e			
				REFERRAL NU
4	170		7	
			* st.	
	1,47			
7	and the second		_	
	3 b 3.d			05/03/0013
above named fam	ily or child was referred by you to this agency to	for Emergency R	esponse intervention on:	05/23/2013 .
esult of the initial	Emergency Response intervention is:			
Does not meet th	ne State requirements for intervention			
Does not meet ti	to diale requirements for intervention			
Allegations appe	ar to be unfounded - case closed			
Allogations conn	ot be substantiated - case closed			
Allegations cann	ot be substantiated - case closed			
Situation stabilize	ed - case closed			
Family has agree	ed to voluntary Social Services			
Case open for se	rvice			
		(Worker)		(Phone #)
Referred to comm	nunity			
agency	-	(Agency Name)		(Agency Phone #)
		, , , , , , , , , , , , , , , , , , , ,		, , , , , , , , , , , , , , , , , , , ,
Referred to Juve	nile Court for Investigation			
MENTS:				
				(Date)
		CSI	V III	(213) 639-4500
	Casaload Number)		Title)	(ZEIS) 033 4300

NAME OF AGENCY:	Depa	artment of Ch	nildren a	nd Famil	y Services Bur	eau of Child	Protection	1	DATE:	03/26/2013
STREET ADDRES	s : 1933	3 S. Broadway	Blvd.,	5th Floo	or					
CITY AND ZIP COL	E: Los	Angeles, Cal	ifornia	90007		COUNTY: Los	Angeles			
NAME OF SOCIAL WOR	KER:				CASELOAD	ID:		TELEP	HONE	
					- 3			(213) 639-45	00
		EMER	GENCY	RESP	ONSE REFE	RRAL INFO	RMATIC	N		
REFERRAL NAME	:		- 5	Day		REFERRAL NU	MBER:			
NA EVALUAT	E	IMMEDIATE		3 DAY	X 5 DAY	10 DAY		N/A SECONDAI REPORT	RY	
				SCRE	ENER INFORM	ATION		1		
NAME					TITLE CSW III			DATE 03/26/		TIME 03:47pm
CASELOAD#				PHONE N	JMBER		ATION			
ALERTS:				(213)	639-4500	Chi	ild Prot	ection H	otline	(CPH)
Palmdale - i		ation to CS	SW			POL	ICE REPORT N	NUMBER		
				- 1	IOME ADDRES	S				
					IONIL ADDICES	3	PHO	ONE NUMBER		
ADDRESS COMMENT	s Rav	7S	S. Serenat W							
CURRENT LOCATION	OF CHILD	(REN)								
				VIC	TIM INFORMAT	ION			T Fig.	
NAME	1 4				AKA (if applicable)			Λ	SOCIA	L SECURITY #
DOB	AGE	AGE CODE	SEX I	ETHNICITY		LANGUA	GF		ICWA F	ELIGIBILITY
505	12	Year(s)	M			24,007	.02		No	ELIGIBLETT
SCHOOL/DAYCARE		-7%	7.			-		-		
SCHOOL/DAYCARE A	DDRESS									
20.70										
ABUSE CATEGORY			ed)	ALLE	GED PERPETRATOR	RNAME				
At Risk, sib						b.				
At Risk, sik					NE # (FOR OPEN CASE	1 1 2 2	3.12			
							ASELOAD #			

	1							
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				VICTIM INFO	ORMATION			
NAME				AKA (if appli				SOCIAL SECURITY #
DOB	AGE	AGE CODE	SEX	ETHNICITY		LANGUAGE		ICWA ELIGIBILITY
	8	Year(s)	М					No
SCHOOL/DAYCARE	NAME							
SCHOOL/DAYCARE	EADDRESS							
ABUSE CATEGORY	(See Screen	er Narrative Attac	hed)	ALLEGED PERP	ETRATOR NAME			
Sexual Abus					enumber Rouss Representation output output			
Sexual Abus	se							
CASE WORKER NA	ME (FOR OPEN	(CASE)	-	PHONE # (FOR O	PEN CASE)	CASELO	AD#	
	-1				4		7	
NAME			77.1	VICTIM INFO				SOCIAL SECURITY #
NAME	261			Arx (II appi	icable)			SOCIAL SECORITY#
DOB	AGE	AGE CODE	SEX	ETHNICITY		LANGUAGE		ICWA ELIGIBILITY
	10	Year(s)	F					No
SCHOOL/DAYCARE	E NAME					1		
SCHOOL/DAYCARE	E ADDRESS							
	10. 11.6							
							1	
ABUSE CATEGORY			hed)	ALLEGED PERP	PETRATOR NAME			
At Risk, si At Risk, si								
CASE WORKER NA				PHONE # (FOR O	PEN CASE)	CASELO	OAD#	
ONOE WORKLEN	<u>(, o, o, o, o</u> ,	. 0, 10=,						
		A) They	777 . 19	OTHERS IN				
NAME				AKA (if app	olicable)			SOCIAL SECURITY #
SEX DAT	E OF BIRTH/A	GE I	LANGUA	GE L			WORK PH	ONE
F	LOI BIRTINA	OL	LANGOA	OL .			Workerin	SHE
ROLE			FOR/TO					
Mother (Bir	rth)							
Mother (Bir	rth)							
Mother (Bin								
CASE WORKER N	IAME			PHONE #		CASELO	DAD #	

				and the African	- 1		
			0	THERS NOT IN TH	E HOME		
NAME				AKA (if applicable)			SOCIAL SECURITY #
			Limeria			Lucay	
SEX	DATE O	F BIRTH/AGE	LANGUAGE			WORK PHONE	
M			FOR/TO				
ROLE No Re	lation		FUR/1U				
	lation						
	lation						
ADDRES					<u> </u>	PRIMARY PHON	IE .
	-						
Unkno	wn, Cal	ifornia					
	ORKER NAM			PHONE #	CASELOAD #		
		<u> </u>					
			0	THERS NOT IN TH	E HOME		
NAME	7 3			AKA (if applicable)			SOCIAL SECURITY #
		w				_	
SEX	DATE O	F BIRTH/AGE	LANGUAGE			WORK PHONE	
M		*	FORTO			1	-
ROLE	-Uncle	(Maternal)	FOR/TO				
		(Maternal)					
		(Maternal)					
ADDRES		(Hacernal)				PRIMARY PHON	IE .
ADDITEO	Ĭ		. 6 :				-
Unkno	wn, Cal	ifornia					
	ORKER NAM			PHONE #	CASELOAD #	1	<u></u>
			CC	LLATERAL INFOR	RMATION	- V 1 1 2	
NAME				*	/1,		S 18
har a si		F					
ROLE			FOR/	то			
400000			<u> </u>	- E		I BRIMARY BUOK	ur.
ADDRES	S					PRIMARY PHON	NE
CONTAC	T DATE	CONTACT METHOD	DESCRIPTI	ON			
CONTAC	TUATE	CONTACT METHOD	DESCRIPTI	ON			

		SS REPORT INFORMATIO	N	
AGENCY	OFFICIAL C	ONTACTED	TITLE	
Palmdale LASD				
ADDRESS			PHONE NUMBER	BADGE NO.
Palmdale LASD				
750 East Avenue Q				
Palmdale, Californi	a 93550			
CROSS REPORTED BY			I DATE & TIME	OF REPORT
			03/26/2	013
		XXX		-d
		REFERRAL HISTORY		3 8
REFERRAL ID	CLIENT NAME		REFERRAL ROLE	REFERRAL DATE
ALLEGATION TYPE		ALLEGATION DISPOSITION	Victim	11/22/2004
Physical Abuse		Unfounded		
Thysical house		onrounded		
		REFERRAL HISTORY		
REFERRAL ID	CLIENT NAME	KEI EKKAE MOTOKI	REFERRAL ROLE	REFERRAL DATE
			Victim	10/30/2012
ALLEGATION TYPE		ALLEGATION DISPOSITION		•
Physical Abuse		Inconclusive		
At Risk, sibling ab	oused	Substantiated		
DESERBAL ID	LOUENTNAME	REFERRAL HISTORY	L DESERBAL BOLE	I DESERBAL DATE
REFERRAL ID	CLIENT NAME		REFERRAL ROLE Victim	08/21/2003
ALLEGATION TYPE		ALLEGATION DISPOSITION	VICCIII	00/21/2003
Severe Neglect		Unfounded		
Severe Neglect		Unfounded		
		REFERRAL HISTORY		
REFERRAL ID	CLIENT NAME		REFERRAL ROLE	REFERRAL DATE
ALLEGATION TYPE		LALLECATION DISPOSITION	Victim	02/26/2007
ALLEGATION TYPE Emotional Abuse		Unfounded		
EMOCIONAL ADUSC		onrounded		
		REFERRAL HISTORY		
REFERRAL ID	CLIENT NAME	KEI EKKAE HISTOKT	REFERRAL ROLE	REFERRAL DATE
			Victim	04/13/2011
ALLEGATION TYPE		ALLEGATION DISPOSITION	7° 2	•
General Neglect		Unfounded		
REFERRAL ID	CLIENT NAME	REFERRAL HISTORY	REFERRAL ROLE	REFERRAL DATE
INCI CRIMICID	OLIENT MAINE		Victim	10/30/2012
ALLEGATION TYPE		ALLEGATION DISPOSITION	, Locin	10,00,2012
General Neglect		Substantiated		

Physical Abuse

Inconclusive

		REFERRAL HISTORY		
REFERRAL ID	CLIENT NAME		REFERRAL ROLE	REFERRAL DATE
ALLEGATION TYPE		ALLEGATION DISPOSITION	Victim	02/26/2007
Emotional Abuse		Unfounded		
				4
		REFERRAL HISTORY		
REFERRAL ID	CLIENT NAME		REFERRAL ROLE	REFERRAL DATE
TALLEGATION TYPE		ALL FOATION DISPOSITION	Victim	04/13/2011
ALLEGATION TYPE At Risk, sibling abu	sed	ALLEGATION DISPOSITION Unfounded		
ite nien, bizing dad		onrounded		
		REFERRAL HISTORY		
REFERRAL ID	CLIENT NAME	REFERRAL HISTORY	REFERRAL ROLE	REFERRAL DATE
			Victim	11/22/2004
ALLEGATION TYPE	1	ALLEGATION DISPOSITION	•	
At Risk, sibling abu	sea	Unfounded		
			Signature and the second	
	Louisus	REFERRAL HISTORY		× 3
REFERRAL ID	CLIENT NAME		REFERRAL ROLE Victim	10/30/2012
ALLEGATION TYPE		ALLEGATION DISPOSITION	VICCIII	10/30/2012
At Risk, sibling abu	sed	Substantiated		
		er el de la Roma de Vandana		The Company of the Co
		REFERRAL HISTORY		
REFERRAL ID	CLIENT NAME		REFERRAL ROLE	REFERRAL DATE
ALLEGATION TYPE		ALLEGATION DISPOSITION	Victim	08/21/2003
Substantial Risk		Unfounded		
Substantial Risk		Unfounded		
				* o
		REFERRAL HISTORY		
REFERRAL ID	CLIENT NAME		REFERRAL ROLE	REFERRAL DATE
			Victim	02/26/2007
ALLEGATION TYPE Emotional Abuse		ALLEGATION DISPOSITION Unfounded		
Physical Abuse		Unfounded		
			7	
Property and the second		REFERRAL HISTORY		
REFERRAL ID	CLIENT NAME	REPERRAL HISTORY	REFERRAL ROLE	REFERRAL DATE
			Victim	04/13/2011
ALLEGATION TYPE	1	ALLEGATION DISPOSITION		
At Risk, sibling abu	sea	Unfounded		
DECEDRAL ID	L OUENT WAYE	REFERRAL HISTORY	DESERBE STATE OF THE PARTY OF T	L persent a term
REFERRAL ID	CLIENT NAME		REFERRAL ROLE Perpetrator	REFERRAL DATE 11/22/2004
ALLEGATION TYPE		ALLEGATION DISPOSITION	Torpotrator	11/22/2004
Physical Abuse		Unfounded		
At Risk, sibling abu	sed	Unfounded		

		REFERRAL HISTORY		
REFERRAL ID	CLIENT NAME		REFERRAL ROLE	REFERRAL DATE
ALLEGATION TYPE		ALLEGATION DISPOSITION	Perpetrator	10/30/2012
General Neglect		Substantiated		
Physical Abuse		Inconclusive		
Physical Abuse		Inconclusive		
At Risk, sibling abused		Substantiated		
At Risk, sibling abused		Substantiated		
		REFERRAL HISTORY		
REFERRAL ID	CLIENT NAME		REFERRAL ROLE Perpetrator	REFERRAL DATE 02/16/2007
ALLEGATION TYPE	L	ALLEGATION DISPOSITION	reipeciacoi	02/10/2007
Physical Abuse		Unfounded		
Substantial Risk		Inconclusive		
	1.00			
		REFERRAL HISTORY		
REFERRAL ID	CLIENT NAME		REFERRAL ROLE	REFERRAL DATE
			Perpetrator	08/21/2003
ALLEGATION TYPE Severe Neglect		ALLEGATION DISPOSITION Unfounded		
Substantial Risk		Unfounded		
Substantial Risk		Ulifounded		
		REFERRAL HISTORY		
REFERRAL ID	CLIENT NAME		REFERRAL ROLE	REFERRAL DATE
ALLEGATION TYPE		ALLEGATION DISPOSITION	Perpetrator	02/26/2007
Emotional Abuse		Unfounded		
Emotional Abuse		Unfounded		
Emotional Abuse		Unfounded		
Emotional Abuse		Unfounded		
Emotional Abuse		Unfounded		
General Neglect		Unfounded		
Physical Abuse		Unfounded		
Inysical radge		onrounded		
		REFERRAL HISTORY		
REFERRAL ID	CLIENT NAME		REFERRAL ROLE	REFERRAL DATE
ALLEGATION TYPE		LALLEGATION SIGNOSITION	Perpetrator	04/13/2011
ALLEGATION TYPE General Neglect		ALLEGATION DISPOSITION Unfounded		
3		Unfounded		
At Risk, sibling abused At Risk, sibling abused		Unfounded		
At Risk, sibling abused		Unfounded		

	REPORTER IN	IFORMATION	
IAME	AGENCY OR C	DRGANIZATION	RELATIONSHIP
ADDRESS.			PRIMARY PHONE SECONDARY PHONE
CONTACT DATE CONTACT METHO	D DESCRIPTION		

Deferrel	Number:
Relelia	Number.

Referral Date

03/26/2013

SCREENER NARRATIVE

ALLEGATIONS (Who, What, Where, When, How, Who Else Knows, Why Now?) COLLECT AND RECORD INFORMATION ABOUT THE FOLLOWING RISK FACTORS:

- PRECIPITATING INCIDENT (Severity, frequency; location and description of injury; history of abuse)
- CHILD CHARACTERISTICS (Age, vulnerability, special circumstances; perpetrator's access; behavior, interaction with caretakers, sibling and peers)
- CARETAKER CHARACTERISTICS (Capacity for child care; interaction with children, other caretakers; skill, knowledge; substance abuse, criminal behavior, mental health)
- FAMILY FACTORS (Relationships, support systems; history of abuse; presence of parent substitute; environmental conditions; family strengths)
- DOMESTIC VIOLENCE/ABUSE FACTORS (Safety risks; pattern of assaults on, threats to, and/or stalking of household members; forced social isolation or economic deprivation; weapons present in the home and used as a threat; prior law enforcement or emergency medical response(s); history of domestic violence/abuse; medical neglect; violation of restraining orders; mental health issues; other risk factors)

Information to CSW	at DCFS-Palmdale office,	<u>.</u>
This is a live call.		
Response time: 5 Day.		
Prior DCFS history: referred childre	en have family maintenance cas	e with 6 prior referrals
Caller: therapist at		
	1 8 P	
Domestic violence/mental health i	nformation: caller was not awar	re of any
		e or arry.
Collateral contacts: caller was not a	aware or any.	
School information:		
Physical or developmental disabili	ity: caller was not aware of any.	
Location of incident: unknown.		
Alleged perpetrators:	(aka), mat	ernal great uncle and his
boyfriend,		
Children: 8 yrs,	10 yrs,	, 12 yrs.
	, , , , , , , , , , , , , , , , , , ,	
Report: is an alle	eged victim of sexual abuse by	(aka
and by		re at risk.
and by	4.114	
Caller reported the following informati	told call	er yesterday, that about 3 years
Caller reported the following informations ago, and his boyfrien		sed him. They had
State of California Health and Welfare Agency	SCREENER INFORMATION	Confidential in accordance with
Department of Social Services	SCILLIALIA HAI OKIMATION	Penal Code Section 11167.5 and/or

CHILD I.D.#

Referral Number:		
Referral Date	03/26/2013	

perform oral sex on them. said that said that is the brother of his maternal grandmother (Doe). was not clear whether this abuse happened one time or more than on time. mother, found out about this sexual abuse 5 months ago, when was returned to her. Child does not have contact with alleged perpetrators.	ie
Caller did not have alleged perpetrators' and maternal grandmother's addresses and phone numbers.	
Caller reported that children's father is in prison for drug related charges and his sentence is for 8 years. Caller did not know father's name or his release date.	
Additional/supplemental information: caller was not aware whether family has gang affiliation.	
This referral reflects all the information that the caller provided. Suspected child abuse report was generated.	

NAME OF AGENCY: STREET ADDRESS: 39959 Sierra Highway, Suite 150 CITY AND ZIP CODE: Palmdale, California 93550 COUNTY: Los Angeles NAME OF SOCIAL WORKER CASELOAD ID TELEPHON EMERGENCY RESPONSE NOTICE OF REFERRAL DISPOSITION NAME OF CHILD(REN)	
CITY AND ZIP CODE: Palmdale, California 93550 COUNTY: Los Angeles NAME OF SOCIAL WORKER CASELOAD ID TELEPHON EMERGENCY RESPONSE NOTICE OF REFERRAL DISPOSITION	
NAME OF SOCIAL WORKER CASELOAD ID TELEPHON EMERGENCY RESPONSE NOTICE OF REFERRAL DISPOSITION	
EMERGENCY RESPONSE NOTICE OF REFERRAL DISPOSITION	
	CHILD ID NUM
	REFERRAL NUM
•	
e above named family or child was referred by you to this agency for Emergency Response intervention on: 03/26/2013 .	
e above harried family of child was referred by you to this agency for Emergency Response intervention on.	
result of the initial Emergency Response intervention is:	
Does not meet the State requirements for intervention	
Allegations appear to be unfounded - case closed	
Allegations cannot be substantiated - case closed	
Situation stabilized - case closed	
Family has agreed to voluntary Social Services	
Case open for service	
(Worker) (Phone #)	
Referred to community agency	
(Agency Name) (Agency Phone	e #)
Referred to Juvenile Court for Investigation	
IMENTS:	
MENTO.	
(Date	e)
(Caseload Number) (Title) (Telephone	Ni mah s -1

NAME OF AGENCY:	Department of Post /BFA	Children and	Family Services	s Emergency Resp	onse Command	DATE: 10/31	/2012
STREET ADDRESS :	1933 S. Broad	dway Blvd., 5th	n Floor				
CITY AND ZIP CODE :	Los Angeles,	California 900	007	COUNTY: L	os Angeles		
NAME OF SOCIAL WORKER	835		CAS	ELOAD ID :		TELEPHONE	
						(213) 639-4500	
	EME	RGENCY R	ESPONSE R	EFERRAL INF	ORMATION		
REFERRAL NAME:		- A/C	10/30/12	REFERRAL N	IUMBER:		
NA EVALUATE OUT	X IMMEDIA	ATE 3 DA	AY 5 D	AY 10 D	AY N/A S REPO	ECONDARY PRT	
		5	CREENER INF	ORMATION	108 M.T. 10		
IAME			TITLE	III		ATE TIME 0/30/2012 04:19	2~~
CASELOAD #		PH	IONE NUMBER		OCATION	0/30/2012 04:19	pm
ALERTS:		(2	213) 639-450	0 C	hild Protect	ion Hotline (CPH	(1
AW ENFORCEMENT AGE	NCY		HOME ADD	,	OLICE REPORT NUME	BER	
					PHONE	NUMBER	
ADDRESS COMMENTS	RAVS confi	rmation					_
CURRENT LOCATION OF							
Children are at	the home	address.	VICTIM INFO	PMATION			
NAME			AKA (if applica			SOCIAL SECUR	RITY#
			- 1	*			
NACOTO DE LA CONTRACTOR	AGE AGE CODE	NO. 100000 100000 100000 100000 100000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 100000 10000 10000 10000 10000 10000 10000 10000 10000 10000 100000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 1	NICITY	LANG	UAGE	ICWA ELIGIBILI	ITY
	11 Year(s	s) M				No	
SCHOOL/DAYCARE NAME					1		
SCHOOL/DAYCARE ADDR	ESS						
			I				
ABUSE CATEGORY (See	Screener Narrative A	ttached)	ALLEGED PERPET	RATOR NAME			
Physical Abuse	D ODEN CASE		PHONE # (FOR OPE	N CASE)	CASELOAD #		

CHILD(RENS)	NAME (S)						CHILD ID
OTHED(INEITO)	The same (0)						
				V	CTIM INFORMATIO	N .	
NAME			100	V	AKA (if applicable)	N	SOCIAL SECURITY #
TWO WATER					The same of the sa		
DOB	AG	E AGE CODE	SEX	ETHNICI	TY	LANGUAGE	ICWA ELIGIBILITY
	7	Year(s)	M				Not Asked
SCHOOL/DAY	CARE NAME					1 1 1 1 1	•
SCHOOL/DAY	CARE ADDRESS	S					
8 225		1 22002					
		eener Narrative Attac	:hed)	A	LLEGED PERPETRATOR NA	ME	
Physical							
CASE WORKE	R NAME (FOR O	PEN CASE)		P	HONE # (FOR OPEN CASE)	CASELOAD#	
	Restrict Co.						
				V	ICTIM INFORMATIO	N	L account of current
NAME					AKA (if applicable)		SOCIAL SECURITY #
DOD	1 40	E ACE CODE	Leev	ETHNICI	TV	LANGUAGE	ICWA ELIGIBILITY
DOB	AG 9	E AGE CODE Year(s)	SEX	ETHNICI	11	LANGUAGE	No
SCHOOL/DAY	CARE NAME	rear (5)	L	1			NO
JOHOOLDAT	OAKE WANE						
0011001/04/	OADE ADDDES						
SCHOOL/DAY	CARE ADDRES	5					
		N maranaran					
ADUSE CATE	COBY (See Ser	eener Narrative Attac	shod)	ΙΛ	LLEGED PERPETRATOR NA	ME	
	sibling		ileu)	l l î	ELEGED FERFE TRATOR NA	IVIL	
	ER NAME (FOR O			P	HONE # (FOR OPEN CASE)	CASELOAD#	
CAGE WORKE	IN NAME (FOR O	I LIT ONOL)			TIONE II (FOR OF EN ONOE)	0,10220,1011	
		Section 1	1	01	THERS IN THE HOM	F	
NAME				U	AKA (if applicable)	_	SOCIAL SECURITY #
SEX	DATE OF BIRT	H/AGE	LANGUA	AGE			WORK PHONE
F							
ROLE	R .		FOR/TO				
Mother	(Birth)						
Mother	(Birth)						

Mother (Birth)

CASE WORKER NAME

CASELOAD#

PHONE #

NAME			OTHERS NOT IN THE AKA (if applicable)	HOME	SOCIAL SECURITY
NAME			AKA (If applicable)		SOCIAL SECURITY
SEX	DATE OF BIRTH/AGE	LANGUAGE			WORK PHONE
F					
ROLE		FOR/TO			•
	(Half)				
	(Half)				
	(Half)				
ADDRESS					PRIMARY PHONE
CASE WOR	RKER NAME		PHONE #	CASELOAD #	1
CASE WOR	KKEK NAME		THORE #	ONOLEGAD II	
			OTHERS NOT IN THE	HOME	
NAME			AKA (if applicable)	HOME	SOCIAL SECURITY
SEX	DATE OF BIRTH/AGE	LANGUAGE	•		WORK PHONE
M					
ROLE		FOR/TO			
Brothe					
	r (Half)				
Brothe	r				PRIMARY PHONE
ADDRESS					FRIMART FRONE
CASE WOR	RKER NAME		PHONE #	CASELOAD #	#
		11			
un die					
100			COLLATERAL INFORM	MATION	
NAME					
ROLE		FO	PR/TO		
ADDRESS					PRIMARY PHONE
					FRIMARI FRONE
ADDRESS					
ADDRESS					

CHILD(RENS) NAME (S)

CHILD I.D. #

	CRO	SS REPORT INFORMAT	TION		
AGENCY	OFFICIAL O	CONTACTED		TITLE	
Palmdale LASD					
ADDRESS	·		PHONE NUMBE	R	BADGE NO.
Palmdale LASD					
750 East Avenue Q					
Palmdale, Californi	a 93550				
CROSS REPORTED BY				DATE & TIME	OF REPORT
				10/30/20	05:24pm
		REFERRAL HISTORY			
REFERRAL ID	CLIENT NAME	KEI EKKAL IIIOTOKI	REFE	RRAL ROLE	REFERRAL DATE
			Vic	tim	11/22/2004
ALLEGATION TYPE		ALLEGATION DISPOSITION	NC		
Physical Abuse		Unfounded			
		r it and			
		REFERRAL HISTORY			
REFERRAL ID	CLIENT NAME			RRAL ROLE	REFERRAL DATE
		LAU EGATION DISPOSITIO	Vic	tim	08/21/2003
ALLEGATION TYPE Severe Neglect		Unfounded	ON		
Severe Neglect		Unfounded			
Severe Negrece		onrounded	Section 1		
		REFERRAL HISTORY			
REFERRAL ID	CLIENT NAME	KEI EKKAE IIIOTOKI	REFE	RRAL ROLE	REFERRAL DATE
			Vic	tim	02/26/2007
ALLEGATION TYPE		ALLEGATION DISPOSITION	ON		*
Emotional Abuse		Unfounded			
Parallel and the		DESERBAL LUCTORY			
REFERRAL ID	CLIENT NAME	REFERRAL HISTORY	I REFE	RRAL ROLE	REFERRAL DATE
THE ENVIOLED			Vic		04/13/2011
ALLEGATION TYPE		ALLEGATION DISPOSITION	ON		•
General Neglect		Unfounded			
	or realize the published		Allelida		
		REFERRAL HISTORY			
REFERRAL ID	CLIENT NAME	28		RRAL ROLE	REFERRAL DATE
				tim	11/22/2004
ALLEGATION TYPE At Risk, sibling ab	nusad	Unfounded	ON		
AL KISK, SIDIING at	Juseu	onrounded			
		REFERRAL HISTORY			
REFERRAL ID	CLIENT NAME	REFERRAL HISTORY	I RFFF	RRAL ROLE	REFERRAL DATE
THE STRUCTURE	Veneral III wife			tim	02/26/2007

ALLEGATION TYPE Emotional Abuse ALLEGATION DISPOSITION

Unfounded

		REFERRAL HISTORY		
REFERRAL ID	CLIENT NAME		REFERRAL ROLE	REFERRAL DATE
ALLEGATION TYPE		ALLEGATION DISPOSITION	Victim	02/26/2007
Emotional Abuse		Unfounded		
		REFERRAL HISTORY		
REFERRAL ID	CLIENT NAME	KEI EKKAE HISTOKT	REFERRAL ROLE	REFERRAL DATE
		A	Victim	04/13/2011
ALLEGATION TYPE		ALLEGATION DISPOSITION		
At Risk, sibling abu	isea	Unfounded		
	LOUENTHINE	REFERRAL HISTORY	I perenny noue	I DESERBAL DATE
REFERRAL ID	CLIENT NAME		REFERRAL ROLE Victim	REFERRAL DATE 11/22/2004
ALLEGATION TYPE	Agricon A.	ALLEGATION DISPOSITION	VICCIM	11/22/2001
At Risk, sibling abo	used	Unfounded		
		REFERRAL HISTORY		
REFERRAL ID	CLIENT NAME		REFERRAL ROLE	REFERRAL DATE
		ALLEGATION PROPOSITION	Victim	08/21/2003
ALLEGATION TYPE Substantial Risk		Unfounded		
Substantial Risk		Unfounded		
MEGLINE WAY		100		
- 20 P	- 17-3 - 10e en 172 -	REFERRAL HISTORY		
REFERRAL ID	CLIENT NAME	REFERRAL HISTORY	REFERRAL ROLE	REFERRAL DATE
			Victim	02/26/2007
ALLEGATION TYPE		ALLEGATION DISPOSITION		
Emotional Abuse		Unfounded Unfounded		
Physical Abuse		Unifounded		
		DESERBELL HIGHERY		
REFERRAL ID	CLIENT NAME	REFERRAL HISTORY	REFERRAL ROLE	REFERRAL DATE
REFERRALID	CEIENT NAME		Victim	04/13/2011
ALLEGATION TYPE		ALLEGATION DISPOSITION		
At Risk, sibling abo	used	Unfounded		
		REFERRAL HISTORY		
REFERRAL ID	CLIENT NAME		REFERRAL ROLE	REFERRAL DATE
ALLEGATION TYPE		ALLEGATION DISPOSITION	Victim	02/26/2007
Emotional Abuse		Unfounded		
General Neglect		Unfounded		
				(A5
STANTON STORY		REFERRAL HISTORY		
REFERRAL ID	CLIENT NAME	_	REFERRAL ROLE	REFERRAL DATE
			Victim	04/13/2011
ALLEGATION TYPE		ALLEGATION DISPOSITION		

		REFERRAL HISTORY		
REFERRAL ID	CLIENT NAME		REFERRAL ROLE	REFERRAL DATE
			Perpetrator	11/22/2004
ALLEGATION TYPE		ALLEGATION DISPOSITION		
Physical Abuse		Unfounded		
At Risk, sibling abused		Unfounded		
		REFERRAL HISTORY		
REFERRAL ID	CLIENT NAME	THE ENGLE MOTOR!	REFERRAL ROLE	REFERRAL DATE
			Perpetrator	02/16/2007
ALLEGATION TYPE		ALLEGATION DISPOSITION		
Physical Abuse		Unfounded		
Substantial Risk	1	Inconclusive		
		REFERRAL HISTORY		
REFERRAL ID	CLIENT NAME	ILL ENIAL HOTORT	REFERRAL ROLE	REFERRAL DATE
			Perpetrator	08/21/2003
ALLEGATION TYPE	THE YEAR OWN	ALLEGATION DISPOSITION		
Severe Neglect		Unfounded		
Substantial Risk	Jah din se	Unfounded		
	Cal Section			
		REFERRAL HISTORY		
REFERRAL ID	CLIENT NAME		REFERRAL ROLE Perpetrator	02/26/2007
ALLEGATION TYPE		ALLEGATION DISPOSITION	Perpetrator	02/20/2007
Emotional Abuse		Unfounded		
Emotional Abuse		Unfounded		
Emotional Abuse		Unfounded		
Emotional Abuse		Unfounded		
Emotional Abuse		Unfounded		
		Unfounded		
General Neglect				
Physical Abuse		Unfounded		
		REFERRAL HISTORY		
REFERRAL ID	CLIENT NAME	TEL ENGLE HOTORY	REFERRAL ROLE	REFERRAL DATE
CONTRACTOR	A CONTRACTOR OF THE CONTRACTOR		Perpetrator	04/13/2011
ALLEGATION TYPE	A 2000 H	ALLEGATION DISPOSITION		
General Neglect		Unfounded		
At Risk, sibling abused	ĺ	Unfounded		
At Risk, sibling abused		Unfounded		
At Risk, sibling abused		Unfounded		

		RI	EPORTER INFORMATION	
IAME			AGENCY OR ORGANIZATION	RELATIONSHIP
DDRESS				PRIMARY PHONE
80				SECONDARY PHONE
CONTACT DATE	CONTACT METHOD	DESCRIPT	ION	•

CHILD I.D. #

Referral Number

Referral Date

10/30/2012

SCREENER NARRATIVE

ALLEGATIONS (Who, What, Where, When, How, Who Else Knows, Why Now?) COLLECT AND RECORD INFORMATION ABOUT THE FOLLOWING RISK FACTORS:

- 1. PRECIPITATING INCIDENT (Severity, frequency; location and description of injury; history of abuse)
- 2. CHILD CHARACTERISTICS (Age, vulnerability, special circumstances; perpetrator's access; behavior, interaction with caretakers, sibling and peers)
- 3. CARETAKER CHARACTERISTICS (Capacity for child care; interaction with children, other caretakers; skill, knowledge; substance abuse, criminal behavior, mental health)
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Report Method:	Telephone	
Response Time:		
DCFS History:		
Domestic Rage:		
Drugs/Alcohol:		
Mental Health:	No	
Gang Activity:	No	
,		
Location of Incid	ent:	
Home Address		
(c	cell)	
Perpetrator:		
	- Mother	
(0	ell)	
Reporting Party:	<u> </u>	
		Confidential in accordance with

Referral Number:

Referral Date 10/30/2012

20.1746
(cell)
Referred child, (7 yrs), (9 yrs), and (11 yrs), are alleged victims of physical abuse by their mother,
Background: Prior 2011 referral documented that mother's other daughter, was living with her father, at at a second of the son, and the sound of the
Mother has a history of using illicit drugs. Mother's current boyfriend is
Report: Earlier today (10/30/12), child disclosed that his mother hits him with the buckle end of the belt when he can't finish his homework. sometimes bleeds from being hit by the belt buckle. informed the Caller that he has bruises on his back where mother hit him. Mother also hits and with a belt. was worried that his mother was going to hit him later today because he didn't understand his homework.
further stated that mother makes him sit up all night when he doesn't finish his homework. Caller is not sure if really meant that he stays up all night.
demonstrated how to snort cocaine. Caller is worried that drugs in the home.

NAME OF AGENCY:	Department of Children and Family S	Services	DEPARTMENT/ DIVISION:	Bureau of Operations
STREET ADDRESS:	39959 Sierra Highway, Suite 150		*	
CITY AND ZIP CODE:	Palmdale, California 93550		COUNTY:	Los Angeles
	NAME OF SOCIAL WORKER		CASELOAD ID	TELEPHONE
	EMERGENCY RESPO	NSE NOTICE O	E REFERRAL DI	SPOSITION
The same of the same of	NAME OF CHILD(F		T KEI EKKAL DI	CHILD ID NUM
				REFERRAL NU
			_	
			1	
			-1	
			_	
Allegations cann	ar to be unfounded - case closed ot be substantiated - case closed ed - case closed ed to voluntary Social Services			
I allilly has agree	su to voluntary occiai ocivices			
Case open for se	rvice			
Case open for se	rvice	(Worker)		(Phone #)
		(Worker)		(Phone #)
Referred to comm		(Worker)		(Phone #)
		(Worker) (Agency Name)		(Phone #) (Agency Phone #)
Referred to commagency	nunity			
Referred to commagency				
Referred to commagency Referred to Juve	nunity			
Referred to commagency	nunity			
Referred to commagency Referred to Juve	nunity			
Referred to commagency Referred to Juve	nunity			
Referred to commagency Referred to Juve	nunity			(Agency Phone #)
Referred to commagency Referred to Juve	nunity	(Agency Name)	SW I	



Referral ID: Referral Name: Created:			- ERCPPLCMNTPALMJC	Assessment Date: Approving Unit:	5/23/2013 ERCP ON DUTY SCSW
			/26/2013 by	County of Completion:	Los Angeles
Approv	al Statu	s: A	pproved 5/28/2013 by	Last Update:	5/26/2013 by
Assess	ment Ty	pe: (Initial Review/Update OR	eferral Closing	
Housel	hold Nar	ne:		Were there allegations in this h	ousehold?
Factors	Influen	cing Ch	ild Vulnerability		
disc	nificant d order		d medical or mental	ned mental capacity (e.g., develo ned physical capacity on-ambulatory, limited use of lim	
	1: SAFI		REATS AND PROTECTIVE CAPACI	TIES	
7 1.	⊙ Yes	ONo	Caregiver caused serious physical harm physical harm in the current investigat Serious injury or abuse to child oth Caregiver fears he/she will maltrea Threat to cause harm or retaliate a Excessive discipline or physical form Drug-exposed infant.	tion, as indicated by: ther than accidental. the child. the child.	e threat to cause serious
2.	⊙ Yes	ONo	Current circumstances, combined with maltreated a child in his/her care, sugbased on the severity of the previous rincident.	gest that the child's safety may b	pe of immediate concern
7 3.	Oyes	⊙ No	Child sexual abuse is suspected, and c immediate concern.	ircumstances suggest that the ch	nild's safety may be of
7 4.	⊙ Yes	ONo	Caregiver fails to protect the child from include physical abuse, sexual abuse,		rm by others. This may
7 5.	⊙ Yes	ONo	Caregiver's explanation for the injury to injury, and the nature of the injury sug		
7 6.	Oyes	⊙ No	The family refuses access to the child,	or there is reason to believe tha	t the family is about to flee.
? 7.	Oyes	⊙ No	Caregiver does not meet the child's im or mental health care.	mediate needs for supervision, f	ood, clothing, and/or medical

?	9.	0	Yes	⊙ No	Caregiver's current substance abuse seriously impairs his/her ability to supervise, protect, or care for the child.					
?	10.	0	Yes	ONo	Domestic violence exists in the home and poses an imminent danger of serious physical and/or emotional harm to the child.					
7	11.	0	Yes	O No	Caregiver describes the child in predominantly negative terms or acts toward the child in negative ways that result in the child being a danger to self or others, acting out aggressively, or being severely withdrawn and/or suicidal.					
?	12.	0	Yes	⊙ No	Caregiver's emotional stability, developmental status, or cognitive deficiency seriously impairs his/her current ability to supervise, protect, or care for the child.					
?	13.	0	Yes	⊙ No	Other (specify):					
PART	В:	Prote	ective	Capaci	ities					
				·						
7	1.		Child	has the	e cognitive, physical, and emotional capacity to participate in safety interventions.					
?	2.		Care	giver ha	s the cognitive, physical, and emotional capacity to participate in safety interventions.					
?	3.		Care	giver ha	s a willingness to recognize problems and threats placing the child in imminent danger.					
?	4.		Care	giver ha	s ability to access resources to provide necessary safety interventions.					
?	5.			-	s supportive relationships with one or more persons who may be willing to participate in safety D caregiver is willing and able to accept their assistance.					
7	6.			ast one o	caregiver in the home is willing and able to take action to protect the child, including asking offending leave.					
?	7.				willing to accept temporary interventions offered by worker and/or other community agencies, operation with continuing investigation/assessment.					
?	8.		There	e is evid	ence of a healthy relationship between caregiver and child.					
7	9.		Care	giver is	aware of and committed to meeting the needs of the child.					
?	10.		Care	giver ha	s history of effective problem solving.					
?	11.		Othe	r <i>(specit</i>	5y):					
SECT	101	1 2:	SAFE	TY INT	TERVENTIONS					
?] 1		Inter	vention	or direct services by worker. (DO NOT include the investigation itself.)					
?] 2		Use	of family	y, neighbors, or other individuals in the community as safety resources.					
7] 3		Use	of comm	nunity agencies or services as safety resources.					
?] 4		Have	the car	regiver appropriately protect the victim from the alleged perpetrator.					
?] 5		Have	the alle	eged perpetrator leave the home, either voluntarily or in response to legal action.					

?	6.	Have the non-offending caregiver move to a safe environment with the child.
?	7.	Legal action planned or initiated—child remains in the home.
?	8.	Other (specify):
?	9.	Have the caregiver voluntarily place the child outside the home.

10. Child placed in protective custody because interventions 1-9 do not adequately ensure the child's safety.

- 1. No safety threats were identified at this time. Based on currently available information, there are no children likely to be in immediate danger of serious harm.
- One or more safety threats are present. Without effective preventive services, the planned arrangement for the child will be out-of-home care (e.g., foster family, group home). Safety interventions have been initiated and the child will remain in the home as long as the safety interventions mitigate the danger. A SAFETY PLAN IS REQUIRED FOR CHILD TO REMAIN IN THE HOME.
- 3. V One or more safety threats are present, and placement is the only protecting intervention possible for one or more children. Without placement, one or more children will likely be in danger of immediate or serious harm.

SECTION 4: COMMENTS

Staff Person Comments:

No Staff Comments

Supervisor Comments:



previously maltreated a child in his/her care, suggest that the child's safety may be of immediate concern based on the severity of the previous maltreatment or the caregiver's response to the previous incident. 2 3. O Yes O No Child sexual abuse is suspected, and circumstances suggest that the child's safety may be of immediate concern. 4. O Yes O No Caregiver fails to protect the child from serious harm or threatened harm by others. This may include physical abuse, sexual abuse, or neglect.	Referral ID: Referral Name:				Assessment Date: Approving Unit:	4/15/2013 ER -	
Assessment Type:	Create	:d:	4	/17/2013 by	County of Completion:	Los Angeles	
Household Name: Were there allegations in this household?	Appro	val Statu	s: A	pproved 4/30/2013 by	Last Update:	4/17/2013 by	
Age 0-5	Assess	sment Ty	pe: (Initial O Review/Upda	ate Referral Closing		
□ Age 0-5 □ Diminished mental capacity (e.g., developmental delay, non-verbal) □ Significant diagnosed medical or mental disorder □ Diminished physical capacity (e.g., non-ambulatory, limited use of limbs) □ School age, but not attending school □ SAFETY THREATS AND PROTECTIVE CAPACITIES ■ A: Safety Threats □ 1. ○ Yes ○ No □ Caregiver caused serious physical harm to the child or made a plausible threat to cause serious physical harm in the current investigation, as indicated by: □ Serious injury or abuse to child other than accidental. □ Caregiver fears he/she will maltreat the child. □ Threat to cause harm or retaliate against the child. □ Excessive discipline or physical force. □ Drug-exposed infant. □ Current circumstances, combined with information that the caregiver has or may have previously maltreated a child in his/her care, suggest that the child's safety may be of immediate concern based on the severity of the previous maltreatment or the caregiver's response to the previous incident. □ 3. ○ Yes ○ No □ Child sexual abuse is suspected, and circumstances suggest that the child's safety may be of immediate concern. □ 4. ○ Yes ○ No □ Caregiver fails to protect the child from serious harm or threatened harm by others. This may include physical abuse, sexual abuse, or neglect. □ 5. ○ Yes ○ No □ Caregiver's explanation for the injury to the child is questionable or inconsistent with the type of injury, and the nature of the linjury suggests that the child's safety may be of immediate concern. □ 6. ○ Yes ○ No □ The family refuses access to the child, or there is reason to believe that the family is about	House	hold Nan	ne:		Were there allegations in this h	ousehold?	
(e.g., developmental delay, non-verbal) Significant diagnosed medical or mental disorder Diminished physical capacity (e.g., non-ambulatory, limited use of limbs) School age, but not attending school School age, but not attending school Safety Threats 1.	actors	Influen	cing Ch	ild Vulnerability			
□ Significant diagnosed medical or mental □ Diminished physical capacity (e.g., non-ambulatory, limited use of limbs) □ School age, but not attending school □ School age, but not attending school □ Safety Threats □ 1. ○ Yes ○ No	☐ Age	e 0-5				10	
School age, but not attending school CTION 1: SAFETY THREATS AND PROTECTIVE CAPACITIES RT A: Safety Threats 1.			agnosed	d medical or mental		rbal)	
TION 1: SAFETY THREATS AND PROTECTIVE CAPACITIES RT A: Safety Threats 1. O Yes O No Caregiver caused serious physical harm to the child or made a plausible threat to cause serious physical harm in the current investigation, as indicated by: Serious injury or abuse to child other than accidental. Caregiver fears he/she will maltreat the child. Threat to cause harm or retaliate against the child. Excessive discipline or physical force. Drug-exposed infant. 2. O Yes O No Current circumstances, combined with information that the caregiver has or may have previously maltreated a child in his/her care, suggest that the child's safety may be of immediate concern based on the severity of the previous maltreatment or the caregiver's response to the previous incident. 3. O Yes O No Child sexual abuse is suspected, and circumstances suggest that the child's safety may be of immediate concern. 4. O Yes O No Caregiver fails to protect the child from serious harm or threatened harm by others. This may include physical abuse, sexual abuse, or neglect. 5. O Yes O No Caregiver's explanation for the injury to the child is questionable or inconsistent with the type of injury, and the nature of the injury suggests that the child's safety may be of immediate concern. 6. O Yes O No The family refuses access to the child, or there is reason to believe that the family is about					(e.g., non-ambulatory, limited use of	of limbs)	
AT A: Safety Threats 1. O Yes O No Caregiver caused serious physical harm to the child or made a plausible threat to cause serious physical harm in the current investigation, as indicated by: Serious injury or abuse to child other than accidental. Caregiver fears he/she will maltreat the child. Threat to cause harm or retaliate against the child. Excessive discipline or physical force. Drug-exposed infant. 2. O Yes O No Current circumstances, combined with information that the caregiver has or may have previously maltreated a child in his/her care, suggest that the child's safety may be of immediate concern based on the severity of the previous maltreatment or the caregiver's response to the previous incident. 3. O Yes O No Child sexual abuse is suspected, and circumstances suggest that the child's safety may be of immediate concern. 4. O Yes O No Caregiver fails to protect the child from serious harm or threatened harm by others. This may include physical abuse, sexual abuse, or neglect. 5. O Yes O No Caregiver's explanation for the injury to the child is questionable or inconsistent with the type of injury, and the nature of the injury suggests that the child's safety may be of immediate concern. 6. O Yes O No The family refuses access to the child, or there is reason to believe that the family is about		001 age, -	Jul 110c -	Itteriality scrioor			
AT A: Safety Threats 1. Yes No Caregiver caused serious physical harm to the child or made a plausible threat to cause serious physical harm in the current investigation, as indicated by: Serious injury or abuse to child other than accidental. Caregiver fears he/she will maltreat the child. Threat to cause harm or retaliate against the child. Excessive discipline or physical force. Drug-exposed infant. 2. Yes No Current circumstances, combined with information that the caregiver has or may have previously maltreated a child in his/her care, suggest that the child's safety may be of immediate concern based on the severity of the previous maltreatment or the caregiver's response to the previous incident. 3. Yes No Child sexual abuse is suspected, and circumstances suggest that the child's safety may be of immediate concern. 4. Yes No Caregiver fails to protect the child from serious harm or threatened harm by others. This may include physical abuse, sexual abuse, or neglect. 5. Yes No Caregiver's explanation for the injury to the child is questionable or inconsistent with the type of injury, and the nature of the injury suggests that the child's safety may be of immediate concern. 6. Yes No The family refuses access to the child, or there is reason to believe that the family is about	CTION	1: SAFI	тү тн	REATS AND PROTECTIV	F CAPACITIES		
2 1.				ALATO ALLO LILLO	E CAPACITED		
Serious injury or abuse to child other than accidental. Caregiver fears he/she will maltreat the child. Threat to cause harm or retaliate against the child. Excessive discipline or physical force. Drug-exposed infant. 2. O Yes	? 1.	O Yes	⊙ No				
□ Caregiver fears he/she will maltreat the child. □ Threat to cause harm or retaliate against the child. □ Excessive discipline or physical force. □ Drug-exposed infant. 2. ○ Yes							
□ Excessive discipline or physical force. □ Drug-exposed infant. 2. ○ Yes ② No Current circumstances, combined with information that the caregiver has or may have previously maltreated a child in his/her care, suggest that the child's safety may be of immediate concern based on the severity of the previous maltreatment or the caregiver's response to the previous incident. 3. ○ Yes ② No Child sexual abuse is suspected, and circumstances suggest that the child's safety may be of immediate concern. 4. ○ Yes ③ No Caregiver fails to protect the child from serious harm or threatened harm by others. This may include physical abuse, sexual abuse, or neglect. 5. ○ Yes ③ No Caregiver's explanation for the injury to the child is questionable or inconsistent with the type of injury, and the nature of the injury suggests that the child's safety may be of immediate concern. 6. ○ Yes ④ No The family refuses access to the child, or there is reason to believe that the family is about				☐ Caregiver fears he/she	will maltreat the child.		
☐ Drug-exposed infant. ☐ 2. ○ Yes				☐ Threat to cause harm o	or retaliate against the child.		
 O Yes No Current circumstances, combined with information that the caregiver has or may have previously maltreated a child in his/her care, suggest that the child's safety may be of immediate concern based on the severity of the previous maltreatment or the caregiver's response to the previous incident. 3. O Yes No Child sexual abuse is suspected, and circumstances suggest that the child's safety may be of immediate concern. 4. O Yes No Caregiver fails to protect the child from serious harm or threatened harm by others. This may include physical abuse, sexual abuse, or neglect. O Yes No Caregiver's explanation for the injury to the child is questionable or inconsistent with the type of injury, and the nature of the injury suggests that the child's safety may be of immediate concern. 6. O Yes No The family refuses access to the child, or there is reason to believe that the family is about 					physical force.	sical force.	
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immediate concern. 2 4. O Yes O No Caregiver fails to protect the child from serious harm or threatened harm by others. This may include physical abuse, sexual abuse, or neglect. 5. O Yes O No Caregiver's explanation for the injury to the child is questionable or inconsistent with the type of injury, and the nature of the injury suggests that the child's safety may be of immediate concern. 6. O Yes O No The family refuses access to the child, or there is reason to believe that the family is about	2.	O Yes	⊙ No	previously maltreated a chi immediate concern based o	ild in his/her care, suggest that the cl on the severity of the previous maltre	hild's safety may be of	
may include physical abuse, sexual abuse, or neglect. 7 5. O Yes O No Caregiver's explanation for the injury to the child is questionable or inconsistent with the type of injury, and the nature of the injury suggests that the child's safety may be of immediate concern. 7 6. O Yes O No The family refuses access to the child, or there is reason to believe that the family is about		Oyes	@ No	Child sexual abuse is suspe	ected, and circumstances suggest tha	t the child's safety may be s	
type of injury, and the nature of the injury suggests that the child's safety may be of immediate concern. 7 6. O Yes O No The family refuses access to the child, or there is reason to believe that the family is about	? 3.	O ICS	O NO		and circumstances suggest tha	t the child's safety may be t	
and the same of th				immediate concern. Caregiver fails to protect th	he child from serious harm or threater		
	? 4.	O Yes	⊙ No	immediate concern. Caregiver fails to protect th may include physical abuse Caregiver's explanation for type of injury, and the nature	the child from serious harm or threater e, sexual abuse, or neglect.	ned harm by others. This	

7	7.	O Ye	s O No	Caregiver does not meet the child's immediate needs for supervision, food, clothing, and/or medical or mental health care.
?	8.	O Ye	s O No	The physical living conditions are hazardous and immediately threatening to the health and/or safety of the child.
?	9.	O Ye	s O No	Caregiver's current substance abuse seriously impairs his/her ability to supervise, protect, or care for the child.
7	10.	O Ye	s ② No	Domestic violence exists in the home and poses an imminent danger of serious physical and/or emotional harm to the child.
7	11.	O Ye	s O No	Caregiver describes the child in predominantly negative terms or acts toward the child in negative ways that result in the child being a danger to self or others, acting out aggressively, or being severely withdrawn and/or suicidal.
?	12.	O Ye	s O No	Caregiver's emotional stability, developmental status, or cognitive deficiency seriously impairs his/her current ability to supervise, protect, or care for the child.
7	13.	O Ye	s O No	Other (specify):
PART	B: F	rotect	tive Capac	ities
?	1.	□ c	hild has the	e cognitive, physical, and emotional capacity to participate in safety interventions.
?	2.	□ c	aregiver ha	is the cognitive, physical, and emotional capacity to participate in safety interventions.
7	3.	□ c	aregiver ha	is a willingness to recognize problems and threats placing the child in imminent danger.
?	4.	□ c	aregiver ha	is ability to access resources to provide necessary safety interventions.
?	5.		-	is supportive relationships with one or more persons who may be willing to participate in safety ID caregiver is willing and able to accept their assistance.
7	6.			caregiver in the home is willing and able to take action to protect the child, including asking regiver to leave.
?	7.		_	willing to accept temporary interventions offered by worker and/or other community agencies, operation with continuing investigation/assessment.
?	8.	П	here is evic	dence of a healthy relationship between caregiver and child.
7	9.	□ c	aregiver is	aware of and committed to meeting the needs of the child.
7	10.	 c	aregiver ha	s history of effective problem solving.
7	11.	 0	ther (speci	fy):
SECT	TON	2. 54	SEETY IN	TERVENTIONS

- No safety threats were identified at this time. Based on currently available information, there are no children likely to be in immediate danger of serious harm.
- One or more safety threats are present. Without effective preventive services, the planned arrangement for the child will be out-of-home care (e.g., foster family, group home). Safety interventions have been initiated and the child will remain in the home as long as the safety interventions mitigate the danger. A SAFETY PLAN IS REQUIRED FOR CHILD TO REMAIN IN THE HOME.
- 3. One or more safety threats are present, and placement is the only protecting intervention possible for one or more children. Without placement, one or more children will likely be in danger of immediate or serious harm.

SECTION 4: COMMENTS

Staff Person Comments:

No Staff Comments

Supervisor Comments:



Referral ID: Referral Name: Created:			:		A C 10 30 12	Assessment Date: Approving Unit:	11/1/2012 ER -
			1	1/6/2012 b	py ,	County of Completion:	Los Angeles
App	prov	al Statu	ıs: A	approved 12	2/28/2012 by	Last Update:	11/6/2012 by
Ass	sess	ment Ty	rpe: (⊙ Initial	O Review/Update	O Referral Closing	1
Ho	useh	nold Nar	ne:			Were there allegations in t	his household? ② Yes ○ No
Fact	tors	Influen	cing Ch	ild Vulner	ability		
	Age	0-5				minished mental capacity g., developmental delay, no	n-verbal)
	diso	rder		d medical o	or mental Dir (e.	minished physical capacity g., non-ambulatory, limited	The second secon
Ц	Sch	ool age,	but not	attending s	chool		
СТІ	ON	1: SAF	ЕТҮ ТН	REATS A	ND PROTECTIVE CA	APACITIES	
		1: SAFI afety Th		REATS AI	ND PROTECTIVE C	APACITIES	
RT	A: S		reats	Caregive	r caused serious physi	cal harm to the child or mad	de a plausible threat to cause
RT	A: S	afety Th	reats	Caregive serious p	r caused serious physi hysical harm in the cu	cal harm to the child or mad arrent investigation, as indica	
RT	A: S	afety Th	reats	Caregive serious p	r caused serious physi hysical harm in the cu	cal harm to the child or mad irrent investigation, as indica child other than accidental.	
RT	A: S	afety Th	reats	Caregive serious p	r caused serious physi hysical harm in the cu us injury or abuse to c giver fears he/she will	cal harm to the child or mad irrent investigation, as indica child other than accidental.	
RT	A: S	afety Th	reats	Caregiver serious p	r caused serious physi hysical harm in the cu us injury or abuse to c giver fears he/she will	cal harm to the child or made rrent investigation, as indica child other than accidental. maltreat the child. taliate against the child.	
	A: S	afety Th	reats	Caregiver serious p Serio Caregi Threa	r caused serious physionysical harm in the culous injury or abuse to cogiver fears he/she will at to cause harm or re	cal harm to the child or made rrent investigation, as indica child other than accidental. maltreat the child. taliate against the child.	
RT	A: S	afety Th	● No	Caregive serious p Serio Caregi Threa Exces Drug	r caused serious physionysical harm in the curus injury or abuse to orgiver fears he/she will at to cause harm or resistive discipline or physical exposed infant.	cal harm to the child or mach irrent investigation, as indicated child other than accidental. maltreat the child. taliate against the child. sical force. and with information that the in his/her care, suggest that the the severity of the previous machines.	e caregiver has or may have
RT A	1. 2.	O Yes	● No	Caregiver serious p Serio Caregi Threa Exces Druge Current of previously immediate response Child sex	r caused serious physionysical harm in the curus injury or abuse to orgiver fears he/she will at to cause harm or resistive discipline or physical exposed infant. Circumstances, combinally maltreated a child into the previous incides	cal harm to the child or machine investigation, as indicated that the child. maltreat the child. taliate against the child. sical force. med with information that the child/her care, suggest that the severity of the previous ment.	e caregiver has or may have the child's safety may be of naltreatment or the caregiver's
? ?	1. 2. 3.	O Yes	● No No	Caregives serious p Serio Caregi Threa Exces Drug Current of previously immediate response Child sex immediate Caregives	r caused serious physionysical harm in the curus injury or abuse to orgiver fears he/she will at to cause harm or resistive discipline or physical exposed infant. Circumstances, combinate to concern based on the to the previous incidental abuse is suspected the concern.	cal harm to the child or machine investigation, as indicated that the child child other than accidental. It maltreat the child child taliate against the child child force. The ded with information that the in his/her care, suggest that the severity of the previous ment. It and circumstances suggest	e caregiver has or may have the child's safety may be of naltreatment or the caregiver's
RT /	1. 2. 3. 4.	O Yes O Yes	No No No No No No	Caregiver serious p Serio Caregi Threa Exces Drug- Current of previously immediate response Caregiver may included type of in	r caused serious physichysical harm in the curus injury or abuse to cogiver fears he/she will at to cause harm or resistive discipline or physical physical abuse in the concern based on the to the previous incidentation and abuse is suspected the concern. It fails to protect the chude physical abuse, ser's explanation for the	cal harm to the child or machirent investigation, as indicated that the child child other than accidental. It maltreat the child. It that the child child force. The definition of the previous ment. The definition of the previous ment.	e caregiver has or may have the child's safety may be of naltreatment or the caregiver's at that the child's safety may be or reatened harm by others. This onable or inconsistent with the

7 7.	O Yes O No	Caregiver does not meet the child's immediate needs for supervision, food, clothing, and/or medical or mental health care.
? 8.	O Yes ⊙ No	The physical living conditions are hazardous and immediately threatening to the health and/or safety of the child.
7 9.	O Yes O No	Caregiver's current substance abuse seriously impairs his/her ability to supervise, protect, or care for the child.
? 10.	O Yes O No	Domestic violence exists in the home and poses an imminent danger of serious physical and/or emotional harm to the child.
7 11.	○ Yes	Caregiver describes the child in predominantly negative terms or acts toward the child in negative ways that result in the child being a danger to self or others, acting out aggressively, or being severely withdrawn and/or suicidal.
7 12.	O Yes	Caregiver's emotional stability, developmental status, or cognitive deficiency seriously impairs his/her current ability to supervise, protect, or care for the child.
7 13.	O Yes O No	Other (specify):
PART B: F	Protective Capac	ities
7 1.	☐ Child has the	e cognitive, physical, and emotional capacity to participate in safety interventions.
? 2.	☐ Caregiver ha	as the cognitive, physical, and emotional capacity to participate in safety interventions.
7 3.	☐ Caregiver ha	es a willingness to recognize problems and threats placing the child in imminent danger.
7 4.	☐ Caregiver ha	as ability to access resources to provide necessary safety interventions.
7 5.	_	is supportive relationships with one or more persons who may be willing to participate in safety ID caregiver is willing and able to accept their assistance.
? 6.		caregiver in the home is willing and able to take action to protect the child, including asking regiver to leave.
7 7.		willing to accept temporary interventions offered by worker and/or other community agencies, operation with continuing investigation/assessment.
7 8.	☐ There is evic	dence of a healthy relationship between caregiver and child.
7 9.	☐ Caregiver is	aware of and committed to meeting the needs of the child.
7 10.	☐ Caregiver ha	as history of effective problem solving.
7 11.	Other (speci	fy):
SECTION	2: SAFETY IN	TERVENTIONS

-

- No safety threats were identified at this time. Based on currently available information, there are no children likely to be in immediate danger of serious harm.
- One or more safety threats are present. Without effective preventive services, the planned arrangement for the child will be out-of-home care (e.g., foster family, group home). Safety interventions have been initiated and the child will remain in the home as long as the safety interventions mitigate the danger. A SAFETY PLAN IS REQUIRED FOR CHILD TO REMAIN IN THE HOME.
- One or more safety threats are present, and placement is the only protecting intervention possible for one or more children. Without placement, one or more children will likely be in danger of immediate or serious harm.

SECTION 4: COMMENTS

Staff Person Comments:

CSW had face to face contact with the children listed on the referral who reported that they felt safe in the home and in the care of their mother. Ms. admitted to spanking with the belt as she tried alternative methods of disciplining prior to resorting to this method. It was explained to Ms. that this was considered inappropriate discipline and she was advised to continue use of alternate methods. Ms. reports having problems with and feels as though services could benefit the family as his behavioral problems are on going. Mother and significant other submitted to on demand test the following day which returned NEGATIVE results for any controlled substances.

Supervisor Comments:



Referral ID: Referral Name: Created: 6/				IR	Assessment Date: Approving Unit:	4/21/2011 ER
			/6/2011 by	/	County of Completion:	Los Angeles
Appro	oval Stat	us: A	approved 6/	/6/2011 by	Last Update:	6/6/2011 by
Asse	ssment T	уре: (⊙ Initial	O Review/Update	Referral Closing	
Hous	ehold Na	me:			Were there allegations in t	his household? • Yes • No
☐ Ag	ge 0-5 ignificant (sorder	diagnosed	ild Vulner d medical o	Dir (e.	minished mental capacity g., developmental delay, no minished physical capacity g., non-ambulatory, limited	
RT A:	N 1: SAF	hreats	Caregive		ical harm to the child or mad	de a plausible threat to cause
RT A:	Safety T	hreats	Caregive serious p Serio Care Three	er caused serious physion physical harm in the cu ous injury or abuse to o giver fears he/she will	ical harm to the child or mad irrent investigation, as indica child other than accidental. maltreat the child. taliate against the child.	
RT A:	Safety T	• No	Caregive serious previous immedia	er caused serious physionysical harm in the cubus injury or abuse to orgiver fears he/she will at to cause harm or ressive discipline or physic-exposed infant.	ical harm to the child or madurent investigation, as indicated the child of maltreat the child. Italiate against the child or madurent the child. Italiate against the chi	e caregiver has or may have
RT A:	Safety T	o No o No	Caregive serious p Serio Care Three Exce Drug Current of previous immedia response Child sex	er caused serious physionysical harm in the cubus injury or abuse to orgiver fears he/she will at to cause harm or ressive discipline or physionexposed infant. Circumstances, combining maltreated a child in the concern based on the concern	ical harm to the child or maderrent investigation, as indicated in the child of the	e caregiver has or may have the child's safety may be of naltreatment or the caregiver's
RT A:	Safety T O Yes	● No No No	Caregive serious p Serio Care Three Excee Drug Current of previous immedia response Child sex immedia Caregive	er caused serious physionysical harm in the cubus injury or abuse to orgiver fears he/she will at to cause harm or ressive discipline or physionexposed infant. Circumstances, combinate to the previous incident to the previous incident concern.	ical harm to the child or madurent investigation, as indicated that the child. Italiate against the child or madurent investion, as indicated the child. Italiate against	e caregiver has or may have the child's safety may be of naltreatment or the caregiver's
RT A: 7 1 7 2 7 2	Safety T O Yes O Yes O Yes	No No No No No	Caregive serious provious immedia response Child sex immedia Caregive may incli	er caused serious physionysical harm in the cubus injury or abuse to orgiver fears he/she will at to cause harm or ressive discipline or physionexposed infant. Circumstances, combinated a child in the concern based on the to the previous incidental abuse is suspected at the concern. Er fails to protect the clude physical abuse, seems abuse is suspected at the concern.	ical harm to the child or macurent investigation, as indicated that the child. Italiate against the child. Italiat	e caregiver has or may have the child's safety may be of naltreatment or the caregiver's at that the child's safety may be or reatened harm by others. This conable or inconsistent with the

7		7.	Oy	es O N	Caregiver does not meet the child's immediate needs for supervision, food, clothing, and/or medical or mental health care.
[]		8.	Oy	es O N	The physical living conditions are hazardous and immediately threatening to the health and/or safety of the child.
1		9.	Oy	es O N	Caregiver's current substance abuse seriously impairs his/her ability to supervise, protect, or care for the child.
[7		10.	OY	es 🗿 N	Domestic violence exists in the home and poses an imminent danger of serious physical and/or emotional harm to the child.
1		11.	Oy	es O N	Caregiver describes the child in predominantly negative terms or acts toward the child in negative ways that result in the child being a danger to self or others, acting out aggressively, or being severely withdrawn and/or suicidal.
1		12.	Oy	es O N	Caregiver's emotional stability, developmental status, or cognitive deficiency seriously impairs his/her current ability to supervise, protect, or care for the child.
7		13.	OY	es ② N	Other (specify):
PAR	T I	B: P	rote	ctive Cap	acities
			_	Child has	the consistent abusined and constitued approximate another in a fate intermedian
L	?	1.	ш	Child has	the cognitive, physical, and emotional capacity to participate in safety interventions.
C	?	2.		Caregiver	has the cognitive, physical, and emotional capacity to participate in safety interventions.
	?	3.		Caregiver	has a willingness to recognize problems and threats placing the child in imminent danger.
0	7	4.		Caregiver	has ability to access resources to provide necessary safety interventions.
[?	5.		-	has supportive relationships with one or more persons who may be willing to participate in safety AND caregiver is willing and able to accept their assistance.
[?	6.			ne caregiver in the home is willing and able to take action to protect the child, including asking caregiver to leave.
[?	7.	_	_	is willing to accept temporary interventions offered by worker and/or other community agencies, cooperation with continuing investigation/assessment.
E	?	8.		There is e	vidence of a healthy relationship between caregiver and child.
[?	9.		Caregiver	is aware of and committed to meeting the needs of the child.
[?	10.		Caregiver	has history of effective problem solving.
[?	11.		Other (sp	ecify):

SECTION 2: SAFETY INTERVENTIONS

- No safety threats were identified at this time. Based on currently available information, there are no children likely to be in immediate danger of serious harm.
- One or more safety threats are present. Without effective preventive services, the planned arrangement for the child will be out-of-home care (e.g., foster family, group home). Safety interventions have been initiated and the child will remain in the home as long as the safety interventions mitigate the danger. A SAFETY PLAN IS REQUIRED FOR CHILD TO REMAIN IN THE HOME.
- One or more safety threats are present, and placement is the only protecting intervention possible for one or more children. Without placement, one or more children will likely be in danger of immediate or serious harm.

SECTION 4: COMMENTS

Staff Person Comments:

No Staff Comments

Supervisor Comments:



Referral ID: Referral Name:			:		- AC N H	ollywood	Assessment Date: Approving Unit:	3/21/2007 ER
	ate	d: val Statu	Δ	/22/2007 I pproved 3/	723/2007 by		County of Completion:	Los Angeles 3/22/2007 by
		u . J					ator opaut.	
Ass	ess	ment Ty	/pe: (Initial	O Review/L	Jpdate	O Referral Closing	
Ηοι	useh	old Na	me:				Were there allegations in t	his household?
			cing Ch	ild Vulner	ability	90.27.08		
V	Age	0-5					inished mental capacity ., developmental delay, non-	الجاسي
П	Siar	nificant d	liannosen	d medical o	or mental	_	i., developmental delay, non- iinished physical capacity	-verbai)
_	T	rder	lagiloses	incurca.	n mentai		., non-ambulatory, limited us	se of limbs)
	Sch	ool age,	but not a	attending s	school			
?	1.	_						
	1.	O Yes	No					a plausible threat to cause serious
	1.	O Yes	⊙ No	physical	harm in the cu	irrent inve	estigation, as indicated by:	a plausible threat to cause serious
	1.	O Yes	⊙ No	physical Serio	harm in the cu ous injury or at	urrent inve	estigation, as indicated by: ild other than accidental.	a plausible threat to cause serious
	1.	O Yes	⊙ No	physical Serio	harm in the cu ous injury or at giver fears he/	urrent inve ouse to ch she will m	estigation, as indicated by: ild other than accidental. naltreat the child.	a plausible threat to cause serious
	1.	O Yes	⊙ No	physical Serio Care Thre	harm in the cu ous injury or ab giver fears he/ at to cause had	urrent invenues to che she will m rm or reta	estigation, as indicated by: ild other than accidental. naltreat the child. liate against the child.	a plausible threat to cause serious
	1.	OYes	⊙ No	physical Serio Care Thre Exce	harm in the cu ous injury or at giver fears he/	urrent invenues to che she will m rm or reta e or physic	estigation, as indicated by: ild other than accidental. naltreat the child. liate against the child.	a plausible threat to cause serious
?	2.	O Yes		physical Seric Care Three Exce Drug Current previous immedia	harm in the cubus injury or abgiver fears he/ at to cause had assive disciplined -exposed infarcircumstances, by maltreated a	ouse to che she will m rm or reta e or physic nt. combined a child in I sed on the	estigation, as indicated by: ild other than accidental. haltreat the child. liate against the child. eal force. d with information that the canis/her care, suggest that the severity of the previous malt	aregiver has or may have e child's safety may be of
?	2.		⊙ No	physical Seric Care Three Exce Drug Current previous immedia response	harm in the cubus injury or abgiver fears he/ at to cause had assive disciplined -exposed infarctircumstances, by maltreated at to the previous	ouse to che she will m rm or reta e or physic nt. combined a child in I sed on the us incident	estigation, as indicated by: ild other than accidental. naltreat the child. liate against the child. cal force. d with information that the canis/her care, suggest that the severity of the previous malit.	aregiver has or may have e child's safety may be of
	2.	O Yes	No No No	physical Serice Care Three Exce Drug Current previous immedia response Child serimmedia Caregive	harm in the cubus injury or all giver fears he/at to cause had assive disciplined exposed infarctircumstances, ly maltreated at the concern base to the previous te concern.	ouse to che she will m m or reta e or physic nt. combined a child in the sed on the sus incident uspected,	estigation, as indicated by: ild other than accidental. naltreat the child. liate against the child. cal force. d with information that the canis/her care, suggest that the severity of the previous malt. and circumstances suggest the	aregiver has or may have e child's safety may be of treatment or the caregiver's
?	2.	O Yes O Yes	⊙ No⊙ No⊙ No	physical Serice Care Three Exce Drug Current previous immedia response Child serimmedia Caregive include p	harm in the cubus injury or all giver fears he/at to cause had assive discipline rexposed infarcircumstances, ly maltreated at the concern base to the previous te concern. In fails to prote physical abuse, or's explanation at the nature of the previous ter's explanation at the nature of the protest of th	purent inverse to che some or retar or physical che sor p	estigation, as indicated by: ild other than accidental. haltreat the child. liate against the child. cal force. Id with information that the canis/her care, suggest that the severity of the previous malt. and circumstances suggest that the canis/her care, suggest that the severity of the previous malt.	aregiver has or may have e child's safety may be of treatment or the caregiver's hat the child's safety may be of the child's safety may be of the child's safety may be of the child harm by others. This may able or inconsistent with the type
?	 3. 4. 5. 	O Yes O Yes	⊙ No⊙ No⊙ No⊙ No	physical Serice Care Thre Exce Drug Current previous immedia response Child serimmedia Caregive include p	harm in the cubus injury or abgiver fears he/at to cause had assive discipline rexposed infarcircumstances, by maltreated at the concern base to the previous te concern. It fails to prote physical abuse, or sexplanation and the nature of the previous of the concern.	purse to che she will m rm or reta e or physic nt. combined a child in h sed on the sed on the sus incident uspected, ct the child sexual at n for the inju-	estigation, as indicated by: ild other than accidental. haltreat the child. liate against the child. cal force. Id with information that the canis/her care, suggest that the severity of the previous malt. and circumstances suggest that the canuse, or neglect. Injury to the child is questionally suggests that the child's s	aregiver has or may have e child's safety may be of treatment or the caregiver's hat the child's safety may be of the child's safety may be of the child's safety may be of the child harm by others. This may able or inconsistent with the type

1 - 1		medical or mental health care.
7 8. (Yes O No	The physical living conditions are hazardous and immediately threatening to the health and/or safety of the child.
7 9. (Yes O No	Caregiver's current substance abuse seriously impairs his/her ability to supervise, protect, or care for the child.
7 10.	Yes ② No	Domestic violence exists in the home and poses an imminent danger of serious physical and/or emotional harm to the child.
7 11. (Yes O No	Caregiver describes the child in predominantly negative terms or acts toward the child in negative ways that result in the child being a danger to self or others, acting out aggressively, or being severely withdrawn and/or suicidal.
7 12.	Yes ⊙ No	Caregiver's emotional stability, developmental status, or cognitive deficiency seriously impairs his/her current ability to supervise, protect, or care for the child.
7 13.	Yes	Other (specify):
,		
PART B: Pro	tective Capac	ities
7 1.	Child has the	cognitive, physical, and emotional capacity to participate in safety interventions.
? 2. ☑	Caregiver ha	s the cognitive, physical, and emotional capacity to participate in safety interventions.
7 3. 🔽	Caregiver ha	s a willingness to recognize problems and threats placing the child in imminent danger.
7 4. 🗹	Caregiver ha	s ability to access resources to provide necessary safety interventions.
7 5.		s supportive relationships with one or more persons who may be willing to participate in safety D caregiver is willing and able to accept their assistance.
7 6. ₹		caregiver in the home is willing and able to take action to protect the child, including asking regiver to leave.
7 7.		willing to accept temporary interventions offered by worker and/or other community agencies, peration with continuing investigation/assessment.
7 8. T	There is evid	ence of a healthy relationship between caregiver and child.
7 9. 🗹	Caregiver is	aware of and committed to meeting the needs of the child.
7 10.	Caregiver ha	s history of effective problem solving.
7 11.	Other (specif	<i>'</i> y):

SECTION 2: SAFETY INTERVENTIONS

- No safety threats were identified at this time. Based on currently available information, there are no children likely to be in immediate danger of serious harm.
- One or more safety threats are present. Without effective preventive services, the planned arrangement for the child will be out-of-home care (e.g., foster family, group home). Safety interventions have been initiated and the child will remain in the home as long as the safety interventions mitigate the danger. A SAFETY PLAN IS REQUIRED FOR CHILD TO REMAIN IN THE HOME.
- One or more safety threats are present, and placement is the only protecting intervention possible for one or more children. Without placement, one or more children will likely be in danger of immediate or serious harm.

SECTION 4: COMMENTS

Staff Person Comments:

No Staff Comments

Supervisor Comments:



Risk Assessment

Referral ID: Referral Name:	- 5 Day	Assessment Date: Approving Unit:	5/23/2013 ER -	
Created: 5/23/2013 by		County of Completion:	Los Angeles	
Approval Status	Approved w/ Modifications 6/4/2013 by	Last Update:	6/4/2013 by	, <u> </u>
TION 1: NEGL	ECT INDEX			
				SCOR
N1. Current	Report Is for Neglect			0
			0	
O b. Yes	5		1	
N2. Prior Inv				3
O a. No			-1	
	e or more, <u>abuse</u> only		1	
	e or two for <u>neglect</u>		2	
⊙ d. Th	ree or more for <u>neglect</u>		3	
N3. Househo	old Has Previously Received CPS (volunta	ry/court ordered)		1
O a. No			0	
⊙ b. Ye	5		1	
l Na Nomban	of Children Involved in the Child Abuse/I	Nogloct Tacidont		0
	e, two, or three	Neglect Incident	0	
_	ur or more		1	
5. 10	ar or more		1	
N5. Age of Y	oungest Child in the Home			0
	o or older		0	
O b. Un	der two		1	
4500	eristics of Children in Household			1
	t applicable		0	
	e or more present			
	Developmental, learning, or physical disabili	ty	+1	
	☐ Developmental ☐ Learning			
	Physical			
	Medically fragile or failure to thrive Mental health or behavioral problem		+1	
			+1	

	TOTAL NEGLECT RISK SCORE	10
	☐ Family homeless	
	Physically unsafe	
	O b. One or more apply	
	● a. Not applicable 0	
? N12.	Current Housing	0
	D. Yes	
	Primary Caregiver Has Criminal Arrest History O a. No	1
-		
	☐ Heroin	
	☐ Methamphetamine ☐ Other:	
	☐ Marijuana	
	Drugs ☐ Last 12 months ☑ Prior to the last 12 months	
	Alcohol ☐ Last 12 months ☐ Prior to the last 12 months	
	b. One or more apply	
	O a. None/not applicable 0	
_	Primary Caregiver Has/Had an Alcohol and/or Drug Problem	2
	⊙ b. Yes	
	O a. No	
N9.	Primary Caregiver Has/Had a Mental Health Problem	1
	D. Yes	
_	Primary Caregiver Has a History of Abuse or Neglect as a Child O a. No	1
	O b. Inconsistent with child needs	
	 ⊙ a. Consistent with child needs 	

S	ECT	ION 2: ABUSE INDEX	
			SCORE
	?	A1. Current Report Is for Physical Abuse o a. No b. Yes	O
	?	A2. Number of Prior Investigations	2
		O a. None O b. One or more, neglect only 0	
		O c. One for abuse	
		● d. Two or more for abuse	
	?	A3. Household Has Previously Received CPS (voluntary/court ordered) O a. No b. Yes	1
	?	A4. Prior Physical Injury to a Child Resulting from Child Abuse/Neglect or Prior Substantiated Physical Abuse to a Child	0
		 a. None/not applicable b. One or more apply 1 	
		☐ Prior physical injury to a child resulting from CA/N ☐ Prior substantiated physical abuse of a child	
	?	A5. Number of Children Involved in the Child Abuse/Neglect Incident a. One, two, or three	0
		O b. Four or more	
	?	A6. Characteristics of Children in Household O a. Not applicable	1
		 ▶ One or more present □ Delinquency history □ Developmental disability □ Learning disability ☑ Mental health or behavioral problem 	
1 4 4	?	A7. Two or More Incidents of Domestic Violence in the Household in the Past Year • a. No	O
		O b. Yes	
	?	● a. No	0
		O b. Yes	
	?	A9. Primary Caregiver Is Domineering a. No b. Yes 1	0
		1	

A10. Primary Caregiver Has a History of Abuse or Neglect as a Child		0
	0	
O b. Yes	1	
A11. Primary Caregiver Has/Had a Mental Health Problem		1
O a. No	0	
b. One or more apply	1	
✓ During the last 12 months		
Prior to the last 12 months		

ORED RISK LEVEL	
? Neglect Risk Level: \	Very High
? Abuse Risk Level:	High
? Scored Risk Level:	Very High
ERRIDES	
Policy Overrides (increa	uses risk level to very high)
O Policy override	
☐ Sexual abuse of	case AND the perpetrator is likely to have access to the child.
	injury to a child under age two years.
☐ Severe non-ac	cidental injury.
☐ Caregiver action	on or inaction resulted in the death of a child due to abuse or neglect (previous or current).
Discretionary Override	(increases risk level one level)
O Discretionary overr	ide
Override risk level:	
Discretionary Ove	erride Reason:
No Overrides (no chang	e to risk level)
No override	
IAL RISK LEVEL	
The final risk level is: Ve	ry High
COMMENDED DECISION	
The recommended dec	isjon is: Promote
	Promote
	cision and planned action do not match, explain why:

1. Prim	nary	Caregi	ver Cha	racteristics
?	a.	O Yes	⊙ No	Blames child
?	b.	O Yes	⊙ No	Provides insufficient emotional/psychological support
2. Seco	ond	ary Care	egiver C	haracteristics
	No S	Secondar	ry Careg	iver
?	a.	Oyes	⊙ No	Has a history of abuse/neglect as a child
7	b.	Oyes	⊙ No	Has/had mental health problem
				☐ During the last 12 months
				☐ Prior to the last 12 months
?	c.	O Yes	⊙ No	Has/had an alcohol and/or drug problem
				Alcohol
				Last 12 months Prior 12 months
				Drugs
				☐ Last 12 months ☐ Prior 12 months
				☐ Marijuana ☐ Cocaine
				☐ Methamphetamine ☐ Other:
				☐ Heroin
?	d.	O Yes	⊙ No	Employs excessive/inappropriate discipline
?	e.	O Yes	⊙ No	Domineering
2	f.	① Yes	0	Secondary caregiver has a criminal arrest history

SECTION 5: COMMENTS

Staff Person Comments:

No Staff Comments

Supervisor Comments:

SCSW updated this risk assessment to show prior risk assessments and what was completed on those assessments such as abuse as a child, mental health and drug use in the past. This assessment is specfically for the sexual abuse referral however, a subsequent referral was called in on 5/23/13 for physcial abuse which will have a risk assessment completed regarding those allegation.



Risk Assessment

PRODUCTION Extract Date: 05/28/2013 Server: NCCDWEB1

		al ID: al Name:	ERCPPLCMNTPALMJC	Assessment Date: Approving Unit:	5/23/2013 ERCP ON DUTY	SCSW	
Cr	eate	d:	5/26/2013 by	County of Completion:	Los Angeles		
A	prov	val Status:	Approved 5/28/2013 by	Last Update:	5/26/2013 by		
СТ	ION	1: NEGLEC	T INDEX				
							SCORE
?	N1.	Current Re	port Is for Neglect				0
-		⊙ a. No	port 15 for Hegical			0	
		O b. Yes				1	
						•	
?	N2.	Prior Inves	tigations				3
		O a. None				-1	
		O b. One o	or more, <u>abuse</u> only			1	
		O c. One o	or two for <u>neglect</u>			2	
		⊙ d. Three	or more for <u>neglect</u>			3	
?	N3.	Household	Has Previously Received CPS (voluntary,	/court ordered)			1
		O a. No				0	
		⊙ b. Yes				1	
7	N4.	Number of	Children Involved in the Child Abuse/Ne	glect Incident			0
		⊙ a. One,	two, or three			0	
		O b. Four	or more			1	
?	N5.		ngest Child in the Home				0
			or older			0	
		O b. Under	rtwo			1	
?	N6.		stics of Children in Household				1
		O a. Not a	pplicable			0	
			r more present				
			evelopmental, learning, or physical disability Developmental Learning			+1	
			Physical edically fragile or failure to thrive			. 1	
		1000	ental health or behavioral problem			+1	
7	N7	Primary Ca	regiver Provides Physical Care of the Chi	ld That Ic			1
EI.	147.	O a.	regiver Frovides Filysical care of the Chi	III IIIGL 15			•

	TOTAL NEGLECT RISK SCORE	8
	☐ Family homeless	
	Physically unsafe	
	O b. One or more apply	
	⊙ a. Not applicable 0	
N12.	Current Housing	0
	•	
	O b. Yes	
☐ 14TT.	a. No	
l N44	Primary Caregiver Has Criminal Arrest History	0
	☐ Heroin	
	Methamphetamine Other:	
	☐ Marijuana ☐ Cocaine	
	☐ Last 12 months ☑ Prior to the last 12 months	
	Drugs	
	Alcohol ☐ Last 12 months ☐ Prior to the last 12 months	
	② b. One or more apply	
	O a. None/not applicable 0	
] N10.	Primary Caregiver Has/Had an Alcohol and/or Drug Problem	2
	O b. Yes	
	⊙ a. No	
N9.	Primary Caregiver Has/Had a Mental Health Problem	0
	- J. Tes	
	O b. Yes	
] N8.	Primary Caregiver Has a History of Abuse or Neglect as a Child ② a. No	0
_		
	⊕ b. Inconsistent with child needs 1	
	Consistent with child needs 0	

SECT	ION 2: ABUSE INDEX	
		SCORE
7	A1. Current Report Is for Physical Abuse	1
	O a. No	
	⊕ b. Yes 1	
W	5 7 165	
7	A2. Number of Prior Investigations	2
	O a. None	
	⊙ d. Two or more for abuse 2	
	and the shall be provided by Provided CDC (solunbary (source and anoth)	1
?	A3. Household Has Previously Received CPS (voluntary/court ordered) O a. No	
	D. Yes	
7	A4. Prior Physical Injury to a Child Resulting from Child Abuse/Neglect or Prior Substantiated Physical	
_	Abuse to a Child	0
	a. None/not applicable	
	O b. One or more apply	
	☐ Prior physical injury to a child resulting from CA/N	
	Prior substantiated physical abuse of a child	
7	A5. Number of Children Involved in the Child Abuse/Neglect Incident	o
	② a. One, two, or three	
	O b. Four or more	
	1 at tour of more	
7	A6. Characteristics of Children in Household	1
	O a. Not applicable	
	◆ b. One or more present	
	☐ Delinquency history	
	☐ Developmental disability	
	☐ Learning disability	
	✓ Mental health or behavioral problem	
7	A7. Two or More Incidents of Domestic Violence in the Household in the Past Year O a. No	1
	⊙ b. Yes	
7	A8. Primary Caregiver Employs Excessive/Inappropriate Discipline	1
_ <u></u>	O a. No	
	⊙ b. Yes	
7	A9. Primary Caregiver Is Domineering	1
	O a. No	
	⊙ b. Yes	

Prior to the last 12 months		
☐ During the last 12 months		
O b. One or more apply	1	
⊙ a. No	0	
? A11. Primary Caregiver Has/Had a Mental Health Problem		0
O D. Tes	1	
O b. Yes		
 A10. Primary Caregiver Has a History of Abuse or Neglect as a Child a. No 	0	0

COF	RED RISK LEVEL
	? Neglect Risk Level: High
	? Abuse Risk Level: Very High
	? Scored Risk Level: Very High
VEF	RRIDES
	Policy Overrides (increases risk level to very high)
	Policy override
	☐ Sexual abuse case AND the perpetrator is likely to have access to the child.
	☐ Non-accidental injury to a child under age two years.
	Severe non-accidental injury.
	☑ Caregiver action or inaction resulted in the death of a child due to abuse or neglect (previous or current).
ı	Discretionary Override (increases risk level one level)
	O Discretionary override
	Override risk level:
	Discretionary Override Reason:
ı	No Overrides (no change to risk level)
	O No override
NA	L RISK LEVEL
٦	The final risk level is: Very High
cc	MMENDED DECISION
	The recommended decision is: Promote
	Planned action: Promote O Do Not Promote

SECTION	4: SI	JPPLEM	IENTAL	QUESTIONS
1. Pri	mary	y Caregi	ver Cha	racteristics
?	a.	⊙ Yes	O No	Blames child
?	b.	⊙ Yes	ONo	Provides insufficient emotional/psychological support
2. Se	cond	ary Care	egiver C	characteristics
☑	No	Seconda	ry Careg	iver
7] a.	Oyes	ONo	Has a history of abuse/neglect as a child
?) b.	OYes	ONo	Has/had mental health problem
				During the last 12 months
				Prior to the last 12 months
[?) c.	Oyes	ONo	Has/had an alcohol and/or drug problem Alcohol Last 12 months Prior 12 months
				Drugs Last 12 months Prior 12 months
				☐ Marijuana ☐ Cocaine ☐ Methamphetamine ☐ Other:
				☐ Heroin
?] d.	O Yes	O No	Employs excessive/inappropriate discipline
?) e.	O Yes	O No	Domineering
7] f.	O Yes	O No	Secondary caregiver has a criminal arrest history

SECTION 5: COMMENTS	
Staff Person Comments:	
No Staff Comments	
Supervisor Comments:	
No Supervisor Comments	



Risk Assessment

PRODUCTION Extract Date: 05/28/2013 Server: NCCDWEB1

Referral I	van de la companya del companya de la companya del companya de la	Assessment Date: Approving Unit:	12/28/2012 ER -	
Created:	12/28/2012 by	County of Completion:	Los Angeles	
Approval	Status: Approved 12/28/2012 by	Last Update:	12/28/2012 by	ŀ
SECTION 1:	: NEGLECT INDEX			
				SCORE
7 N1. C	urrent Report Is for Neglect			o
	a. No		0	
0	b. Yes		1	
7 N2. P	rior Investigations			3
	a. None		-1	
0	b. One or more, <u>abuse</u> only		1	
	c. One or two for <u>nealect</u>		2	
	d. Three or more for <u>neglect</u>		3	
7 N3. H	ousehold Has Previously Received CPS (volu	ntary/court ordered)		0
) a. No	,,,	0	_
	b. Yes		1	
7 N4. N	umber of Children Involved in the Child Abus	se/Neglect Incident		0
0	a. One, two, or three		0	
0	b. Four or more		1	
7 N5. A	ge of Youngest Child in the Home			0
	a. Two or older		0	
0	b. Under two		1	
7 N6. C	haracteristics of Children in Household			1
0	a. Not applicable		0	
0	b. One or more present			
	☐ Developmental, learning, or physical disa	ability	+1	
	☐ Developmental			
	☐ Learning ☐ Physical			
	☐ Medically fragile or failure to thrive		+1	
	✓ Mental health or behavioral problem		+1	
7 N7. P	rimary Caregiver Provides Physical Care of tl	ne Child That Is		0

	тот	AL NEGLECT RISK SCORE	8
	☐ Family homeless		
	☐ Physically unsafe		
	O b. One or more apply	1	
		0	
7 N12.	. Current Housing		0
	- 103	1	
	O b. Yes	1	
., .,	⊚ a. No	0	•
7 N11	. Primary Caregiver Has Criminal Arrest History		0
	☐ Heroin		
	☐ Methamphetamine ☐ Other:		
	☐ Marijuana ☑ Cocaine		
	Drugs ☐ Last 12 months ☑ Prior to the last 12 months		
	Last 12 months Prior to the last 12 months		
	Alcohol	2	
	None/not applicable b. One or more apply	0	
7 N10.	Primary Caregiver Has/Had an Alcohol and/or Drug Problem a. None/not applicable		2
_			_
	⊕ b. Yes	1	
	O a. No	0	
? N9.	Primary Caregiver Has/Had a Mental Health Problem		1
	⊙ b. Yes	1	
	O a. No	0	
? N8.	. Primary Caregiver Has a History of Abuse or Neglect as a Child		1
	O b. Inconsistent with child needs	1	
	a. Consistent with child needs	0	

SECT	CTION 2: ABUSE INDEX			
				SCORE
?	A1. Current Report Is for Physical Abuse O a. No		0	1
	⊙ b. Yes		1	
?	A2. Number of Prior Investigations O a. None			2
	O b. One or more, neglect only		-1 0	
	O c. One for abuse		1	
	⊙ d. Two or more for abuse		2	
7	•	(voluntary/court ordered)		0
	⊙ a. No		0	
	O b. Yes		1	
?	Abuse to a Child	g from Child Abuse/Neglect or Prior Substantiated Physica	I	0
	a. None/not applicable		0	
	O b. One or more apply		1	
	Prior physical injury to a child resPrior substantiated physical abus			
?		d Abuse/Neglect Incident		0
	a. One, two, or three		0	
	O b. Four or more		1	
?		1		1
	O a. Not applicable		0	
	b. One or more present		1	
	Delinquency history			
	Developmental disabilityLearning disability			
	Mental health or behavioral prob	lem		
7	A7. Two or More Incidents of Domestic Viole	ence in the Household in the Past Year		o
	⊙ a. No		0	
	O b. Yes		1	
?	A8. Primary Caregiver Employs Excessive/I	nappropriate Discipline	0	1
	⊙ b. Yes		1	
7	A9. Primary Caregiver Is Domineering			0
	⊕ a. No		0	
	O b. Yes		1	

	TOTAL ABUSE RISK SCORE	7
Prior to the last 12 months		
During the last 12 months		
b. One or more apply	1	
	0	
O a. No		
7 A11. Primary Caregiver Has/Had a Menta	Health Problem	1
J. Yes	1	
⊙ b. Yes	0	
O a. No	0	
7 A10. Primary Caregiver Has a History of A	buse or Neglect as a Child	1

CORED RISK LEVEL	
? Neglect Risk Level: H	igh
? Abuse Risk Level: V	ery High
? Scored Risk Level: V	ery High
VERRIDES	
Policy Overrides (increas	ses risk level to very high)
O Policy override	
☐ Sexual abuse ca	ase AND the perpetrator is likely to have access to the child.
■ Non-accidental	injury to a child under age two years.
■ Severe non-acc	idental injury.
☐ Caregiver action	n or inaction resulted in the death of a child due to abuse or neglect (previous or curren
Discretionary Override	(increases risk level one level)
O Discretionary overrio	de
Override risk level:	
Discretionary Ove	rride Reason:
No Overrides (no change	to risk level)
No override	
INAL RISK LEVEL	
The final risk level is: Ver	y High
ECOMMENDED DECISION	<u> </u>
7 The recommended decis	sion is: Promote
	romote O Do Not Promote
Flatined action.	Tomote O Do Not Florilote

SECTIO	N 4:	SL	IPPLEM	IENTAL	QUESTIONS
1.	Prim	ary	Caregi	ver Cha	racteristics
743	?	a.	O Yes	⊙ No	Blames child
	7	b.	O Yes	⊙ No	Provides insufficient emotional/psychological support
2.	Seco	onda	ary Care	egiver C	haracteristics
		No S	Seconda	ry Careg	iver
	7	a.	Oyes	⊙ No	Has a history of abuse/neglect as a child
	7	b.	O Yes	⊘ No	Has/had mental health problem During the last 12 months Prior to the last 12 months
	?	c.	Oyes	⊙ No	Has/had an alcohol and/or drug problem Alcohol Last 12 months Prior 12 months Drugs Last 12 months Prior 12 months Marijuana Cocaine
					☐ Methamphetamine ☐ Other: ☐ Heroin ☐ Other:
	?	d.	O Yes	⊙ No	Employs excessive/inappropriate discipline
	?	e.	Oyes	⊙ No	Domineering
	?	f.	O Yes	⊙ No	Secondary caregiver has a criminal arrest history

SECTION 5: COMMENTS

Staff Person Comments:

Ms. reports on going behavioral problems with minor (7) indicating that she is willing to accept services for him and that she feels as though mental health services will benefit the family. In addition, Ms. also agreed to a UFA. On 11/27/2012, a FP screening was conducted and the case was accepted to receive FP services. On 11/27/2012, CSW contacted mother to inform her that the case was accepted, where she indicated she was still interested in services. As a result, this CSW will promote this referral on a Voluntary Family Maintenance basis for continued supervision by the Department and implementation of Family Preservation services.

Supervisor Comments:

No Supervisor Comments



Risk Assessment

PRODUCTION Extract Date: 05/28/2013 Server: NCCDWEB1

Referral ID: Referral Name:	IR	Assessment Date: Approving Unit:	6/8/2011 ER	
Created:	6/8/2011 by	County of Completion:	Los Angeles	
Approval Status:	Approved 6/13/2011 by	Last Update:	6/8/2011 by	
ECTION 1: NEGLE	ECT INDEX			
				SCOR
N1. Current F	Report Is for Neglect			1
O a. No			0	
⊕ b. Yes			1	
N2. Prior Inv	estigations			2
O a. Nor	ne		-1	
O b. One	or more, <u>abuse</u> only		1	
⊙ c. One	e or two for <u>neglect</u>		2	:
O d. Thr	ee or more for <u>neglect</u>		3	ı
N3. Househo	ld Has Previously Received CPS (volu	ntary/court ordered)		0
⊙ a. No			0	1
O b. Yes			1	
N4. Number	of Children Involved in the Child Abus	se/Neglect Incident		0
⊙ a. One	e, two, or three		C)
O b. For	r or more		1	. [
N5. Age of Yo	oungest Child in the Home			0
⊙ a. Two	o or older		0)
O b. Und	der two		1	Lo H
N6. Characte	ristics of Children in Household			o
⊙ a. Not	applicable		()
O b. One	or more present			
	Developmental, learning, or physical disa	ability	+1	L.
	Developmental			
	☐ Learning ☐ Physical			
	Medically fragile or failure to thrive		+1	L
	Mental health or behavioral problem		+1	
	Caregiver Provides Physical Care of t	he Child That Is		0
⊙ a.				

	TOTAL NEGLECT RISK SCORE	3
	☐ Family homeless	
	Physically unsafe	
	O b. One or more apply	
N12.	Current Housing ② a. Not applicable 0	0
	D. Yes	
J N11.	a. No	J
l N44	Primary Caregiver Has Criminal Arrest History	0
	Heroin	
	☐ Methamphetamine ☐ Other:	
	☐ Marijuana ☐ Cocaine	
	Drugs Last 12 months Prior to the last 12 months	
	☐ Last 12 months ☐ Prior to the last 12 months	
	Alcohol	
	O b. One or more apply	
] N10.	Primary Caregiver Has/Had an Alcohol and/or Drug Problem	0
	D. Yes	
N9.	Primary Caregiver Has/Had a Mental Health Problem a. No	0
		_
	O b. Yes	
] N8.	Primary Caregiver Has a History of Abuse or Neglect as a Child	0
	O b. Inconsistent with child needs	

SECT	TON 2: ABUSE INDEX	
		SCORE
7	A1. Current Report Is for Physical Abuse	0
		0
	O b. Yes	1
		•
7	A2. Number of Prior Investigations	2
_		1
	O b. One or more, neglect only	0
	O c. One for abuse	1
	② d. Two or more for abuse	2
		-
?	A3. Household Has Previously Received CPS (voluntary/court ordered)	0
	⊙ a. No	0
	O b. Yes	1
7	A4. Prior Physical Injury to a Child Resulting from Child Abuse/Neglect or Prior Substantiated Physical Abuse to a Child	0
	a. None/not applicable	0
	O b. One or more apply	1
	☐ Prior physical injury to a child resulting from CA/N	
	☐ Prior substantiated physical abuse of a child	
7	A5. Number of Children Involved in the Child Abuse/Neglect Incident	1
	O a. One, two, or three	0
	⊕ b. Four or more	1
?	A6. Characteristics of Children in Household	0
		0
	O b. One or more present	1
	☐ Delinquency history	
	☐ Developmental disability	
	Learning disability	
	Mental health or behavioral problem	
[3]	A7. Two or More Incidents of Domestic Violence in the Household in the Past Year	0
	a. No	0
	O b. Yes	
		1
7	A8. Primary Caregiver Employs Excessive/Inappropriate Discipline	o
_	⊕ a. No	0
	O b. Yes	1
?	A9. Primary Caregiver Is Domineering	0
	⊙ a. No	0
	O b. Yes	1

A10	Primary Caregiver Has a History of Abuse or Neglect as a Child		0
	⊙ a. No	0	
	O b. Yes	1	
] A11	Primary Caregiver Has/Had a Mental Health Problem		0
	⊙ a. No	0	
	O b. One or more apply	1	
	During the last 12 months		
	During the last 12 months		
	Prior to the last 12 months		

CORE	D RISK LEVEL
	Neglect Risk Level: Moderate
	Abuse Risk Level: Moderate
0	Scored Risk Level: Moderate
VERR	IDES
Po	licy Overrides (increases risk level to very high)
	O Policy override
	☐ Sexual abuse case AND the perpetrator is likely to have access to the child.
	☐ Non-accidental injury to a child under age two years.
	Severe non-accidental injury.
	☐ Caregiver action or inaction resulted in the death of a child due to abuse or neglect (previous or current).
Di	scretionary Override (increases risk level one level)
	O Discretionary override
	Override risk level:
	Discretionary Override Reason:
No	Overrides (no change to risk level)
	No override
INAL	RISK LEVEL
Th	e final risk level is: Moderate
RECOM	MENDED DECISION
?	The recommended decision is: Do Not Promote
	Planned action: O Promote O Do Not Promote

1. Prin	nary	Caregi	ver Cha	racteristics
?	a.	O Yes	⊙ No	Blames child
7	b.	OYes	⊙ No	Provides insufficient emotional/psychological support
2. Seco	ond	ary Care	giver C	haracteristics
	No s	Secondai	y Careg	iver
7	a.	Oyes	⊙ No	Has a history of abuse/neglect as a child
7	b.	Oyes	⊙ No	Has/had mental health problem During the last 12 months Prior to the last 12 months
7	c.	O Yes	⊙ No	Has/had an alcohol and/or drug problem Alcohol Last 12 months Prior 12 months
				Drugs Last 12 months Prior 12 months Marijuana Cocaine Methamphetamine Other: Heroin
7	d.	O Yes	⊙ No	Employs excessive/inappropriate discipline
7	e.	O Yes	⊙ No	Domineering
7	f.	O Yes	@ N=	Secondary caregiver has a criminal arrest history

SECTION 5: COMMENTS	
Staff Person Comments:	
No Staff Comments	
Supervisor Comments:	
No Supervisor Comments	

* Preliminary Report *

Result Type:

History & Physical (IP Physician)

Result Date:

May 23, 2013 11:00

Result Stalus:

Unauth

Performed By: Encounter info:

* Preliminary Report *

History & Physical

DO NOT USE PROHIBITED ABBREVIATIONS

Chief Complaint: Polytrauma

History of Present Illness: is an 8 year old male that was found in cardiopulmonary arrest by EMT after his parents called 911 reporting that he had "fell in the bath." CPR was initiated and lasted at least 15 minutes per report, the result of which is that he regained spontaneous circulation. He arrived at where a blood gas was 6.96/51/156//-21. He received aggressive fluid resuscitation including 5 units of pRBCs (hgb ~4 -> hgb ~14) and 2 of FFP. He received crystalloid resuscitation as well. He remained with a GCS of 3 throughout this chain of events and without spontaneous respirations. His CXR had a white out of his RUL, his head and neck CT showed a small right parietal hematoma, right tentorial subdural hematoma, questionable right parietal punctate lesion, air in the right masticator space, traumatic extraction of upper incisors, deviation of the nasal septum, no c-spine fx, and diffuse soft tissue edema circumferentially around the neck. The chest and abdominal plain fils showed opacities in the lung fields likely representing pulmonary contusion, metallic objects lodged beneath the skin thought to be beebees, and several rib fractures with callous formation. Attempts to oxygenate and ventilate him were met with difficulty. Even with spontaneous cardiovascular circulation he kept his sats in the 60's for a long time. Neurosurgery evaluated him at the OSH and determined that there was nothing to be gained from draining the ICH. was transferred to for a higher level of pediatric trauma care. CT Scan of the abdoman also showed Grade 3-4 liver laceration and pt was transfused multiple units at OSH prior to transfer.

Unable to obtain history - parents in police custody and child unconscious. The police arrested the parents and took the two siblings out of the house and a forensics team has already taken extensive photos of the injuries he sustained.

Review of Systems: _Unobtainable

Past Medical History: _Unobtainable Past Surgical History: Unobtainable

Printed by:

Printed on:

05/24/13 08:28

Page 1 of 8 (Continued)

Preliminary Report *

Birth History: _Unobtainable

Developmental History: _Unobtainable

Nutrition: Unobtainable

Allergies: No known allergies

Home Medications: _Unobtainable

Immunizations: _Unobtainable

Family History: _Unobtainable Social History: _Unobtainable

PMD Name: _

PMD Phone Number: _

PHYSICAL EXAMINATION

Growth Parameters

Welght:

Height:

Head Circumference:

(05/23/13 06:00)

Weight Percentile:

65%

Height Percentile:

Circumference Percentile:

Vital Signs

Heart Rate

TMAX:

0.00

135 bpm 14 Breaths/Min

(05/24/13 04:05) (05/24/13 04:05) (05/23/13 20:00)

Systolic Blood Pressure Diastolic Blood Pressure

92 mm HG 73 mm HG

(05/23/13 20:00)

Art. Systolic Blood Pressure 149 mm HG

(05/24/13 04:00)

Art. Diastolic Blood Pressure 107 mm HG

Respiratory Rate

124 mm HG

(05/24/13 04:00)

Arterial Line MAP

(05/24/13 04:00)

CVP

16 mm HG

(05/24/13 04:00)

General Appearance: Battered, malnourished young man Intubated lying motionless HEENT: Depressed skull fracture on crown with overlying fluctuant hematoma, raccoon eyes

Neck: circumferential abrasion

Chest: Left chest rises more than right chest

Respiratory: Coarse lung sounds b/l

Printed by:

Printed on:

05/24/13 08:28

Page 2 of 8 (Continued)

* Preliminary Report *

Cardiovascular: RRR, S1 and S2

Abdomen: RIgid, distended abdomen, no bowel sounds, with ecchymosis

GU: uncircumcised male, foley in place rigth femoral cordis, left femoral A line. Truama to just above penis

(laceration)

Extremitles: cool, thready pulses, injuries as below

Neurological: No spontansous movements, pupils 4 mm and fixed, no response to pain, no doll's eyes Skin: Multiple bruises, ulcers, and abrasions in various stages of healing. Several hard subcutaneous lumps which x-ray reveals to be beebees. Notable is the 4-5 cm wide circumferential abrasion on his neck, the 4 cm long laceration on his mons pubis extendingdeep into the subcutaneous tissue, hardened ridged skin on right upper

Musculoskeletal: Palpable deformities of the ribs on right lower lateral thorax, swelling and fluctuance of left hand and some of the left fingers, large fluctuance over left knee

Labs (last 24 hrs)

Blood Cell Count (05/23 16:45)

RBC: 5.61

MCV: 84.1 MCH: 29.6

RDW-CV: 17.5 NRBC Percent: 0.4

MPV: 10.2

MCHC: 35.2

Blood Cell Count (05/24 04:05)

RBC: 4.87

MCV: 83.6

MCH: 29.2

MPV: 9.9

RDW-CV: 17.5 NRBC Percent: 0.6

MCHC: 34.9

Chem Panel (05/23 16:45)

159	118	25 / 115 Ca:6.3
3.5	26	0.91
Anlon G	ap: 15	•

Printed by: Printed on:

05/24/13 08:28

Blood Cell Count (05/23 22:30)

RBC: 5.41

MCV: 83.4 MCH: 29.6 MPV: 10.2 RDW-CV: 17.4 NRBC Percent: 0.6

MCHC: 35.5

Chem Panel (05/23 22:30)

			1 ,		
16	53	122	25	/.116	Ca:6.9
3	,9	26	0.96		
			•		

Anion Gap: 15

Page 3 of 8 (Continued)

Preliminary Report

Chem Panel (05/24 04:05)

166	125	26	/123	Ca:6.5
3.7	25	0.97	\	

Anion Gap: 16 Protein Total: 5.5 AST: 125 ALT: 115

Albumin: 2.4

Alk Phos: 221

Bilirubin: 2.0

05/23 05:47

Blood Gas BG crit action: BG crit notify: BG notify D/T: BG read back: Arterial Blood ABG Comment: ABG pH: 7,18 Unit ABG pCO2: 60 nm HG ABG pO2: 62 mm HG ABG HCO3; 22 mEq/L ABG TCO2: 24 mEq/L ABG BE: -7.3 mEq/L ABG 02 Sat: 84 %

ABG FIO2: 100 % Whole Blood Testing Calcium Ionized: 3.3 mg/dL Lactate, WB: 69.3 mg/dL Sodium WB: 148 mEq/L Potassium WB: 2.8 mEq/L Glucose WB: 109 mg/dL Hemoglobin POC: 16.0 g/dL Hematocrit POC: 47.0 %

05/23 08:50 Blood Gas BG crit action: BG crit notify: BG notify D/T:

BG crit action: BG crit notify:

BG notify D/T: BG read back: Arterial Blood ABG Comment: ABG pH: 7.00 Unit

ABG pO2: 110 mm HG ABG HCO3: 29 mEq/L ABG TCO2: 32 mEg/L ABG BE: -6.4 mEg/L

ABG pCO2: 118 mm HG

ABG O2 Sat: 94 % ABG FIO2: 100 % Whole Blood Testing Calcium Ionized: 3.6 mg/dL

Sodium WB: 149 mEq/L Potassium WB: 3.5 mEq/L Glucose WB: 116 mg/dL Hemoglobin POC: 16.1 g/dL

Lactate, WB: 48.1 mg/dL

Hematocrit POC: 47.0 % 05/23 16:44

Blood Gas BG crit action: BG crit notify: BG notify D/T: BG read back: Arterial Blood Mono% M: 2 % Meta% M: 1 %

Abs Neut Calculated: 12.90 K/uL Abs Mono Calculated: 0.28 K/uL

Red Cell Morphology RBC Morph: Reviewed Toxic Gran: Present Dohle Body: Present Polychromasia: Present Burr Cell: Present Schistocyte: Few 05/23 22:30

Routine Coagulation

PT: 16.8 sec PT - Ref: 10.8 PT - INR: 1.6 PTT: 24 sec PTT - Ref: 26

Fibrinogen Level: 690 mg% D-DImer Quantitative: >34.11

mg/L FEU 05/23 22:30 Blood Chemistry Magneslum Lvl: 1.6 mg/dL Phosphorus: 4.9 mg/dL 05/24 00:51

Blood Gas BG crit action: BG crit notify:

Printed by: Printed on:

05/24/13 08:28

Page 4 of 8 (Continued)

* Preliminary Report *

BG read back: Arterial Blood ABG Comment: ABG pH: 7.32 Unit ABG pCO2: 33 mm HG ABG pO2: 240 mm HG ABG HCO3: 17 mEq/L ABG TCO2: 18 mEq/L ABG BE: -7.9 mEq/L ABG 02 Sat: 100 % ABG FIO2: 100 % Whole Blood Testing Calcium Ionized: 2,2 mg/dL Lactate, WB: 41.3 mg/dL Sodium WB: 155 mEq/L Potassium WB: 2.4 mEq/L Glucose WB: 82 mg/dL Hemoglobin POC: 12.4 g/dL Hematocrit POC: 36.0 % 05/23 09:53 **Blood Gas** BG crit action: BG crit notify: BG notify D/T: BG read back: Arterial Blood ABG Comment: ABG pH: 7.36 Unit ABG pCO2: 35 mm HG ABG pO2: 393 mm HG ABG HCO3: 20 mEq/L ABG TCO2; 21 mEq/L ABG BE: -4.5 mEq/L ABG 02 Sat: 100 % ABG FIO2: 100 % Whole Blood Testing Calcium Ionized: 3.2 mg/dL Lactate, WB: 50.1 mg/dL

ABG Comment: ABG pH: 7.42 Unit ABG pCO2: 35 mm HG ABG pO2: 468 mm HG ABG HCO3: 22 mEq/L ABG TCO2: 24 mEq/L ABG BE: -1.3 mEq/L ABG 02 Sat: 100 % ABG FIO2: 100 % Whole Blood Testing Calcium Ionized: 3.0 mg/dL Lactate, WB: 34.3 mg/dL Sodium WB: 157 mEq/L Potassium WB: 3.6 mEg/L Glucose WB: 112 mg/dL Hemoglobin POC: 15,5 g/dL Hematocrit POC: 45.0 % 05/23 16:45 Routine Coagulation PT: 15.4 sec PT - Ref: 10.8. PT - INR: 1.5 PTT: 23 sec PTT - Ref: 26 Fibrinogen Level: 448 mg% D-Dimer Quantitative: 34.11 mg/L FEU Differential Manual Seg% M: 47 % Band% M: 38 % Lymph% M: 2 % Mono% M: 7 % Meta% M: 6 % Abs Neut Calculated: 7.37 K/uL Abs Mono Calculated: 0.61 K/uL Red Cell Morphology RBC Morph: Reviewed Polychromasia: Present Schistocyte: Few

BG notify D/T: BG read back: Arterial Blood ABG Comment: ABG pH: 7.49 Unit ABG pCO2: 28 mm HG ABG p02: 464 mm HG ABG HCO3: 22 mEq/L ABG TCO2: 23 mEq/L ABG BE: -.5 mEq/L ABG 02 Sat: 100 % ABG FIO2: 100 % Whole Blood Testing Calclum Ionized: 3.8 mg/dL Lactate, WB: 52.6 mg/dL Sodium WB: 158 mEq/L Potassium WB: 3.9 mEq/L Glucose WB: 121 mg/dL Hemoglobin POC: 14.1 g/dL Hematocrit POC: 42.0 % 05/24 01:03 Blood Gas BG crlt action: BG crit notify: BG notify D/T: BG read back: Arterial Blood ABG pH: 7.23 Unit ABG pCO2: 63 mm HG ABG pO2: 160 mm HG ABG HCO3: 26 mEq/L ABG TCO2: 28 mEg/L ABG BE: -2.7 mEq/L ABG O2 Sat: 99 % ABG FIO2: 100 % Whole Blood Testing Calcium Ionized: 3.9 mg/dL Lactate, WB: 45.8 mg/dL Sodium WB: 159 mEq/L

Printed by: Printed on:

Sodium WB: 152 mEq/L

05/24/13 08:28

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* Preliminary Report *

Potassium WB: 3.0 mEq/L

Glucose WB: 108 mg/dL

Hemoglobin POC: 14.7 g/dL Hematocrit POC: 43.0 % 05/23 10:13 **Blood Gas** BG crit action: BG crit notify: BG notify D/T: BG read back: Arterial Blood ABG pH: 7.07 Unit ABG pCO2: 93 mm HG ABG pO2: 98 mm HG ABG HCO3: 27 mEq/L ABG TCO2: 30 mEq/L ABG BE: -6.0 mEg/L ABG 02 Sat: 93 % ABG FIO2: 100 % Whole Blood Testing Calcium Ionized: 3.7 mg/dL Lactate, WB: 50.3 mg/dL

Preliminary Micro BACTERIOLOGY (Pre - 05/23/13 10:41) Drawn 05/23/13 05:30

No growth to date

05/23 10:21

Blood Gas

Sodium WB: 150 mEq/L

Glucose WB: 113 mg/dL

Potassium WB; 3.4 mEg/L

Hemoglobin POC: 16.1 g/dL -Hematocrit POC: 47.0 %

05/23 20:14 Blood Gas BG crit action: BG crit notify: BG notify D/T: BG read back: Arterial Blood ABG Comment: ABG pH; 7,46 Unit ABG pCO2: 34 mm HG ABG pO2: 444 mm HG ABG HCO3: 24 mEg/L ABG TCO2: 25 mEq/L ABG BE: .7 mEq/L ABG O2 Sat: 100 % ABG FIO2: 100 % Whole Blood Testing Calcium Ionized: 3.5 mg/dL Lactate, WB: 50.0 mg/dL Sodium WB: 157 mEq/L Potassium WB: 4.1 mEq/L Glucose WB: 113 mg/dL Hemoglobin POC: 17.3 g/dL Hematocrit POC: 51.0 % 05/23 22:30 Differential Manual Seg% M: 59 % Band% M: 33 %

Lymph% M: 5 %

None

Potassium WB: 3.9 mEq/L Glucose WB: 127 mg/dL Hemoglobin POC: 14.9 g/dL Hematocrit POC: 44.0 % 05/24 04:05 Routine Coagulation PT: 17.8 sec PT - Ref: 10.8 PT - INR: 1.8 PTT: 25 sec PTT - Ref: 26 Fibringen Level: 695 mg% D-Dimer Quantitative: >34.11 mg/L FEU Differential Manual Seg% M: 47 % Band% M: 38 % Lymph% M: 9 % Mono% M: 2 % Meta% M: 3 % Myelo% M: 1 % Abs Neut Calculated: 12.84 K/uL Abs Mono Calculated: 0.30 K/uL Red Cell Morphology RBC Morph: Reviewed Toxic Gran: Present Dohle Body: Present Polychromasla: Present

Positive Micro (last 36 hrs)

Negative Micro (last 36 hrs)

Burr Cell: Present Schistocyte: Few

Is an 8 yo victim of polytrauma that suffered a cardiopulmonary arrest in the field and ASSESSMENT: was resuscitated only with great difficulty and after a long period of hypoxemia and hypotension. He remains

Printed by: Printed on:

05/24/13 08:28

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* Preliminary Report *

without any evidence of brainstem function and first brain death test shows no function. Pt is multisystem truama pt.

PLAN:

CARES team for documentation of injuries

Neuro:

- Pending brain death exam x 2
- Attempt two regulate his chemistries better
- No sedation as he does not seem to require any and we would like to obtain a clear brain death exam

CV

- DA gtt @ 10, titrate for MAPs 60-70
- Give crystalloid as necessar.

F/G

- D5 NS @ NS @ 2/3 mIVF
- Replete electrolytes PRN, follow on chem 8 Q8h and gasses
- FOllow sodium closely, may start DI or cerebral salt wasting.

Respiratory:

- Ventilating on SIMV with high pressures due to increased ab pressure and pulmonary contusion
 - Last settings 40/15
- Oxygenation is better on these high pressures.
- ABGs q2h, keep pH > 7.2

ID:

- Clinda ppx
- Blood cx pending

Signature Line

Author(s): [() MD, Fellow - Pediatric Surgery

Co-Signer(s):

Dictated Date / Time: 05.24.13 05:38

Printed by: Printed on:

05/24/13 08:28

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* Preliminary Report *

Completed Action List:
* Perform by () MD
* Sign by () MD on May 24, 2013 05:38 on May 24, 2013 05:38

Printed by: Printed on:

05/24/13 08:28

Page 8 of 8 (End of Report)

' Preliminary Report *

Result Type:

History & Physical (IP Physician)

Result Date:

May 23, 2013 09:42

Result Status:

Unaulh Performed By:

Encounter info:

MD, on May 23, 2013 10:26 Inpatient, 05/23/13 -

* Preliminary Report *

History & Physical

DO NOT USE PROHIBITED ABBREVIATIONS

Chlef Complaint: Polytrauma

is an B year old male that was found in cardiopulmonary arrest by EMT after History of Present Illness: his parents called 911 reporting that he had "fell in the bath." CPR was initiated and lasted at least 15 minutes per report, the result of which is that he regained spontaneous circulation. He arrived at where a blood gas was 6.96/51/156//-21. He received aggressive fluid resuscitation including 5 units of pRBCs (hgb ~4 -> hgb ~14) and 2 of FFP. He received crystallold resuscitation as well. He remained with a GCS of 3 throughout this chain of events and without spontaneous respirations. His CXR had a white out of his RUL, his head and neck CT showed a small right parietal hematoma, right tentorial subdural hematoma, questionable right parletal punctate lesion, air in the right masticator space, traumatic extraction of upper incisors, deviation of the nasal septum, no c-spine fx, and diffuse soft tissue edema circumferentially around the neck. The chest and abdominal plain fils showed opacities in the lung fields likely representing pulmonary contusion, metallic objects lodged beneath the skin thought to be beebees, and several rlb fractures with callous formation. Attempts to oxygenate and ventilate him were met with difficulty. Even with spontaneous cardiovascular circulation he kept his sats in the 60's for a long time. Neurosurgery evaluated him at the OSH and determined that there was nothing to be gained from draining the ICH. was transferred to for a higher level of pediatric trauma care.

Unable to obtain history - parents In police custody and child unconscious. The police arrested the parents and took the two siblings out of the house and a forensics team has already taken extensive photos of the injuries he sustained.

PHYSICAL EXAMINATION

Growth Parameters

Weight:

(05/23/13 06:00)

Weight Percentile:

65%

Height:

Height Percentile:

Printed by:

Printed on:

05/24/13 08:28

Page 1 of 5 (Continued)



* Preliminary Report *

Head Circumference:

Circumference Percentile:

Vital Signs

IMAX:	0.00	
Heart Rate	158 bpm	(05/23/13 08:31)
Respiratory Rate	20 Breaths/Min	(05/23/13 08:31)
Systolic Blood Pressure	120 mm HG	(05/23/13 08:31)
Diastolic Blood Pressure	97 mm HG	(05/23/13 08:31)
Art. Systolic Blood Pressure	127 mm HG	(05/23/13 08:31)
Art. Diastolic Blood Pressure	68 mm HG	(05/23/13 08:31)
Arterial Line MAP	86 mm HG	(05/23/13 08:31)
CVP	0 mm HG	(05/23/13 06:00)

General Appearance: Battered, malnourished young man intubated lying motionless

HEENT: Depressed skull fracture on crown with overlying fluctuant hematoma, raccoon eyes

Neck: circumferential abrasion

Chest: Left chest rises more than right chest

Respiratory: Coarse lung sounds b/l Cardiovascular: RRR, S1 and S2

Abdomen: RIgid, nondistended abdomen, no bowel sounds

GU: unclrcumcised male, foley in place right femoral cordis, left femoral A line.

Extremities: cool, thready pulses, injuries as below

Neurological: No spontansous movements, pupils 4 mm and fixed, no response to pain, no doll's eyes

Skin: Multiple bruises, ulcers, and abrasions in various stages of healing. Several hard subcutaneous lumps which x-ray reveals to be beebees. Notable is the 4-5 cm wide circumferential abrasion on his neck, the 4 cm long laceration on his mons pubis extendingdeep into the subcutaneous tissue, hardened ridged skin on right upper

Musculoskeletal: Palpable deformities of the ribs on right lower lateral thorax, swelling and fluctuance of left hand and some of the left fingers, large fluctuance over left knee

Labs (last 24 hrs)

Blood Cell Count (05/23 05:30)

RBC: 5.26 MPV: 9.0 MCV: 87.6 RDW-CV: 16.6 MCH: 29.3 NRBC Percent: 2,5

Printed by:

Printed on: 05/24/13 08:28

Page 2 of 5 (Continued)

* Preliminary Report *

MCHC: 33.4

Chem Panel (05/23 05:30)

153	109	20 / 105 Ca:5,9
2.7	26	0.81

AST: 256 Anlon Gap: 20 Protein Total: 5.9 Albumin: 2.7

ALT: 155 Alk Phos: 249 Lipase LvI: 54

05/23 05:30

Bilirubin: 3.2

Routine Coagulation

PT: 14.2 sec PT - Ref: 10.8 PT - INR: 1.4 PT 1:1: 12.1 sec PTT: 24 sec PTT - Ref: 26

Fibrinogen Level: 408 mg% D-Dimer Quantitative: >34.11

mg/L FEU

Differential Automated

Neut %: 70.3 % Lymph %: 24.6 % Mono %: 3.1 % Baso %: 0.5 % IG %: 1.5 % Abs Neut #: 1.37 K/uL 05/23 05:47

Blood Gas BG crit action: BG crit notify:

BG notify D/T:

Preliminary Micro

ABG Comment: ABG pH: 7.18 Unit ABG pCO2: 60 mm HG ABG pO2: 62 mm HG ABG HCO3: 22 mEq/L ABG TCO2: 24 mEq/L ABG BE: -7.3 mEq/L ABG O2 Sat: 84 % ABG FIO2; 100 % Whole Blood Testing Calcium Ionized: 3.3 mg/dL Lactate, WB: 69.3 mg/dL Sodium WB: 148 mEq/L Potassium WB: 2.8 mEq/L

Glucose WB: 109 mg/dL

Hemoglobin POC: 16.0 g/dL

BG read back:

Arterial Blood

Hematocrit POC: 47.0 % 05/23 08:50 **Blood Gas** BG crlt action:

Positive Micro (last 36 hrs)

None

BG notify D/T: BG read back: Arterial Blood ABG Comment: ABG pH: 7.32 Unit ABG pCO2: 33 mm HG ABG pO2: 240 mm HG ABG HCO3: 17 mEq/L ABG TCO2: 18 mEq/L · ABG BE: -7.9 mEq/L ABG O2 Sat: 100 % ABG FIO2: 100 % Whole Blood Testing Calcium Ionized: 2.2 mg/dL

BG crit notify:

Sodium WB: 155 mEq/L Potassium WB: 2.4 mEg/L Glucose WB: 82 mg/dL Hemoglobin POC: 12.4 g/dL Hematocrit POC: 36.0 %

Lactate, WB: 41.3 mg/dL

Negative Micro (last 36 hrs)

None

Printed by: Printed on:

None

05/24/13 08:28

Page 3 of 5 (Continued)

* Preliminary Report *

ASSESSMENT: Is an 8 yo victim of polytrauma that suffered a cardiopulmonary arrest in the field and was resuscitated only with great difficulty and after a long period of hypoxemia and hypotension. He remains without any evidence of brainstem function but we have not yet done a brain death exam on him.

PLAN:

Neuro:

- Pending brain death exam x 2
- Attempt two regulate his chemistries better
- No sedation as he does not seem to require any and we would like to obtain a clear brain death exam

CV:

- DA gtt @ 10, titrate for MAPs 60-70
- Give crystalloid as necessar.

F/G:

- D5 NS @ NS @ 2/3 mIVF
- Replete electrolytes PRN, follow on chem 8 Q8h and gasses
- FOllow sodium closely, may start DI or cerebral salt wasting.

Respiratory:

- Ventilating on SIMV with high pressures due to increased ab pressure and pulmonary contusion
 Last settings 40/15
- Oxygenation is better on these high pressures.
- ABGs q2h, keep pH > 7.2

ID:

- Clinda ppx
- Blood cx pending

Discharge Criteria: _ Anticipated Date of Discharge: _

Signature Line

Author(s): MD,

Physician 3rd Year - Pediatric

Printed by:

Printed on:

05/24/13 08:28

Page 4 of 5 (Continued)



* Preliminary Report *

Co-Signer(s):

Dictated Date / Time: 05.23.13 10:26

Modified Date / Time: 05.23.13 10:26 Modified by:

Completed Action List:

* Perform by on May 23, 2013 10:26 MD, on May 23, 2013 10:26 · Modify by MD, on May 23, 2013 10:27 on May 23, 2013 10:27 on May 23, 2013 10:27 Requested by Modify by MD, MD, * Modify by

on May 23, 2013 * Sign by MD,I

10:27

Printed by: Printed on:

05/24/13 08:28

Page 5 of 5 (End of Report)

14/23

Brain Death Exam Note

* Final Report *

Result Type: Result Date: Brain Death Exam Note

Result Status:

May 24, 2013 01:26 Auth (Verified)

Result Title:

Brain Death Examination

Performed By: Verified By: Encounter info: MD (Attending), MD (Attending)

on May 24, 2013 01:32 on May 24, 2013 01:32

Inpalient, 05/23/13 -

* Final Report *

Brain Death Examination

Patient:

MRN: DOB:

FIN

Age: 8 years Sex: Male

Associated Diagnoses: None

Author:

MD (Attending),

Assessment

First exam, performed >= 24 hours after birth or following cardiopulmonary resuscitation or other severe brain injury.

Date/Time performed: 05/24/2013 01:03:00.

Section 1. PREREQUISITES for brain death examination and apnea test

A. Irreversible and Identifiable Cause of Coma

Traumatic brain injury

B. Correction of contributing factors that can interfere with the neurologic examination

Core Body Temperature is over 35°C (95°F)

Systolic blood pressure or MAP in acceptable range (SBP not less than 2 standard deviations below age appropriate norm) based on age

Sedative/analgesic drug effect excluded as a contributing factor

Metabolic inloxication excluded as a contributing factor

Neuromuscular blockade excluded as a contributing factor

Section 2. Physical Examination

Flaccid tone, patient unresponsive to deep painful stimuli.

Pupils are midposition or fully dilated and light reflexes are absent.

Corneal, cough, gag reflexes are absent.

Oculovestibular OR oculocephalic reflexes are absent.

· Spontaneous respiratory effort while on mechanical ventilation is absent.

Section 3. Apnea Test

Printed by:

Printed on:

05/24/13 08:28

Page 1 of 2 (Continued) May. 24. 2013 9:40AM

Brain Death Exam Note

* Final Report *

Date/Time performed: 05/24/2013 01:03:00.

Test Results

Pretest pH: 7.49

Pretest PaCO2: 28 mmHg Apnea duration: 9 min Postlest pH: 7.23 Postlest PaCO2: 63 mmHg

No spontaneous respiratory efforts were observed despite final PaCO2 >= 60 mm Hg and a >= 20 mm Hg increase above baseline with a concomitant drop in pH to acidotic levels.

Section 5.1. Signature (First Exam)

I certify that my examination is consistent with cessation of all functions of the entire brain, including the brainstem. Confirmatory exam to follow.

Physician Name: MD (Attending), Specially: Pediatric Critical Care.

Completed Action List:

* Perform by MD (Attending) , on May 24, 2013 01:32
* Sign by MD (Attending) , on May 24, 2013 01:32
* VERIFY by MD (Attending) on May 24, 2013 01:32

Printed by: Printed on:

05/24/13 08:28

Page 2 of 2 (End of Report)

NM Brain Scan - Brain Death Detection

* Final Report *

Result Type:

NM Brain Scan - Brain Death Detection

Result Date:

May 23, 2013 15:04

Result Status:

Auth (Verified)

Result Tille:

NM Brain Scan - Brain Death Detection

Performed By:

on May 23, 2013 15:04

Verified By:

(Attending) MD, on May 23, 2013 15:10

Encounter info:

Inpatient, 05/23/13 -

* Final Report *

Reason For Exam

8 yo boy w subdural hematoma, pulm contusion liver laceration & dep skull fractures and multi rib and long bone fractures with cardiac arrest at home. ROSC achieved. Apnea Test cannot be done.

REPORT

DATE OF EXAMINATION: 5/23/2013 COMPARISON: None

HISTORY:

The patient is an 8-year-old male who presents with subdural hematoma, pulmonary contusion and liver laceration. Today's examination is performed to assess brain parenchyma perfusion.

TECHNIQUE:

The patient received intravenous administration of 8.9 mCi of technotium 99m labeled Ceretec via a right femoral IV by TW, CNMT. Dynamic imaging of the head and neck was performed. 20 minutes delayed static scintiphotos in anterior, posterior and lateral projections were obtained. SPECT images were also obtained in the axial, sagittal and coronal projections.

FINDINGS:

There is overall decreased and patchy perfusion to both cerebral hemispheres and cerebellum.

IMPRESSION:

Evidence of perfusion to the brain however as mentioned above it is diffusely decreased and palchy.

Printed by:

Printed on:

05/24/13 08:29

Page 1 of 2 (Continued)

17/23

NM Brain Scan - Brain Death Detection

* Final Report *

Dictated By: .

Dictated On: 05/23/2013 Signed By:

Signature Line
*** Final ***

Electronically Signed By:

(Attending) MD,

on 05/23/2013 15:10

Dictated by: (Atlending) MD,

IMAGE

This document has an image

Completed Action List:

* Order by () MD on May 23, 2013 09:18

* Perform by on May 23, 2013 15:04

"VERIFY by (Allending) MD, on May 23, 2013 15:10

Printed by: Printed on:

05/24/13 08:29

Page 2 of 2 (End of Report)

XR Abdomen 2 view

* Final Report *

Result Type:

XR Abdomen 2 view

Result Date: Result Status May 23, 2013 05:25 Auth (Verified)

Result Title:

XR Abdomen 2 view

Performed By: Verified By: Encounter info: on May 23, 2013 05:25

(Attending) MD,

on May 23, 2013 11:43

Inpatient, 05/23/13 -

* Final Report *

Reason For Exam evaluate abdomen for free air

Date of exam: 5/23/2013 at 5:18 a.m.

Comparison: None

Indications:

Transfer from outside hospital following cardiac and respiratory arrest. At the outside hospital the patient was noted to have bilateral subdural bleeds, grade 3 liver laceration, multiple rib fractures in various stages of healing, multiple burn marks, and multiple BB gun bullet entry sites.

Findings:

Chest series: A portable AP view of the chest is submitted for interpretation. There is diffuse opacification of the right upper lobe and either the right lower lobe or right middle lobe. The right upper lobe is almost completely opacified with only a subtle air bronchogram being present. This could be due to consolidation or contusion however alelectasis could have a similar appearance. There is severe haziness to the left lung. The appearance of the right middle lobe or right lower lobe opacity as well the left lung is more suggestive of pulmonary edema or hemorrhage. There is a small right pleural effusion. There are multiple healing posterior and anterolateral rib fractures. A BB projects over the right mainstern bronchus. An endotracheal tube is present with the tip at the level of clavicles. A nasogastric lube is seen with the tip in left upper quadrant. There is a cardiac monitor lead/resuscitation pad over the heart. The heart does not appear enlarged. There is a density which projects over the proximal right humerus of unclear etiology.

Printed by:

Printed on:

05/24/13 08:29

Page 1 of 3 (Conlinued)

No. P. 20

XR Abdomen 2 view

* Final Report *

Abdomen series: Supine and crosstable lateral views of the abdomen are submitted for interpretation. There is a nonspecific relative paucity of bowel gas with the exception of some nondilated loops of air filled bowel which are centralized. This can be due to free fluid within the abdomen causing centralization of the bowel loops. Also, the overall paucity of bowel gas could be within normal variation but it can also be seen with fluid filled loops of bowel. There is no definite evidence of free air however some of the focal areas of air on the lateral film may not be extraluminal. Correlation with CT exam is recommended. As mentioned with chest x-ray, bilateral healing rib fractures are noted. A nasogastric is seen with the lip left upper quadrant. There is residual contrast within the distended bladder from an earlier exam, Bilateral femoral catheters are noted. There is high density material in some loops of bowel which may be due to residual contrast from the patient's prior CT exam. Subtle nephrograms and renal excretion are noted. This could be due to a more recent CT exam however correlation with the timing of the CT is recommended. If the CT was performed much later this could be due to renal shock. BB's project over the left hip, left scrolum and right upper thigh. There is also a sublle density in the left upper quadrant projecting over the region of the nasogastric tube which is either a part of the other densities seen in the bowel or a foreign body either internal or external to the patient.

Impression:

- Severe lung disease which may be due to a combination of edema, contusion, atelectasis and/or consolidation. Unfortunately, pulmonary hemorrhage cannot be excluded.
- 2. Small right pleural effusion.
- 3. Multiple healing rib fractures.
- 4. Nonspecific bowel gas pattern as described above.
- 5. Multiple BB's projecting over the chest and pelvic region.
- 6. Catheters and tubes as described above.

Dictated By:

Dictated On: 05/23/2013

Signed By:

Signature Line

"" Preliminary Report ""

Printed by:

Printed on:

05/24/13 08:29

Page 2 of 3 (Continued)

03:07:51 p.m. 05-28-2013

May. 24. 2013 9:41AM

XR Abdomen 2 view

Final Report

(Attending) MD

on May 23, 2013 05:25

Printed by: Printed on:

05/24/13 08:29

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Completed Action List:

* Perform by

Page 3 of 3 (End of Report)

20 /23

XR Chest PA

* Final Report *

Result Type:

XR Chest PA

Result Date: Result Status: May 23, 2013 05:25 Auth (Verified)

(Attending) MD,

Result Title:

XR Chest PA

Performed By:

on May 23, 2013 05:25

Verified By:

on May 23, 2013 11:43

Encounter info:

Inpalient, 05/23/13 -

* Final Report *

Reason For Exam evaluate lung fields, ETT, NG

REPORT

Date of exam: 5/23/2013 at 5:18 a.m.

Comparison: None

Indications:

Transfer from outside hospital following cardiac and respiratory arrest. At the outside hospital the patient was noted to have bilateral subdural bleeds, grade 3 liver laceration, multiple rib fractures in various stages of healing, multiple burn marks, and multiple BB gun bullet entry sites.

Findings:

Chest series: A portable AP view of the chest is submitted for Interpretation. There is diffuse opacification of the right upper lobe and either the right lower lobe or right middle lobe. The right upper lobe is almost completely opacified with only a subtle air bronchogram being present. This could be due to consolidation or confusion however atelectasis could have a similar appearance. There is severe haziness to the left lung. The appearance of the right middle lobe or right lower lobe opacity as well the left lung is more suggestive of pulmonary edema or hemorrhage. There is a small right pleural effusion. There are multiple healing posterior and anterolateral rib fractures. A BB projects over the right mainstem bronchus. An endotracheal tube is present with the tip at the level of clavicles. A nasogastric tube is seen with the tip in left upper quadrant. There is a cardiac monitor lead/resuscitation pad over the heart. The heart does not appear enlarged. There is a density which projects over the proximal right humerus of unclear etiology.

Printed by:

Printed on:

05/24/13 08:30

Page 1 of 3 (Continued)

XR Chest PA

* Final Report *

Abdomen series: Supine and crosstable lateral views of the abdomen are submitted for interpretation. There is a nonspecific relative paucity of bowel gas with the exception of some nondilated loops of air filled bowel which are centralized. This can be due to free fluid within the abdomen causing centralization of the bowel loops. Also, the overall paucity of bowel gas could be within normal variation but it can also be seen with fluid filled loops of bowel. There is no definite evidence of free air however some of the focal areas of air on the lateral film may not be extraluminal. Correlation with CT exam is recommended. As mentioned with chest x-ray, bilateral healing rib fractures are noted. A nasogastric is seen with the tip left upper quadrant. There is residual contrast within the distended bladder from an earlier exam. Bilateral femoral catheters are noted. There is high density material in some loops of bowel which may be due to residual contrast from the patient's prior CT exam. Subtle nephrograms and

contrast from the patient's prior CT exam. Subtle nephrograms and renal excretion are noted. This could be due to a more recent CT exam however correlation with the timing of the CT is recommended. If the CT was performed much later this could be due to renal shock. BB's project over the left hip, left scrotum and right upper thigh. There is also a subtle density in the left upper quadrant projecting over the region of the nasogastric tube which is either a part of the other densities seen in the bowel or a foreign body either internal or external to the patient.

Impression:

- 1. Severe lung disease which may be due to a combination of edema, contusion, alelectasis and/or consolidation. Unfortunately, pulmonary hemorrhage cannot be excluded.
- 2, Small right pleural effusion.
- 3. Multiple healing rib fractures.
- 4. Nonspecific bowel gas pattern as described above.
- 5. Multiple BB's projecting over the chest and pelvic region.
- 6. Catheters and tubes as described above.

Dictated By:

Dictated On: 05/23/2013

Signed By:

Signature Line

"" Preliminary Report ""

Printed by:

Printed on:

05/24/13 08:30

Page 2 of 3 (Continued)

03:08:28 p.m.

23 /23

05-28-2013

XR Chest PA

* Final Report *

IMAGE

This document has an image

Completed Action List:
* Perform by

on May 23, 2013 05:25

Printed by: Printed on:

Page 3 of 3 (End of Report)

History & Physical (IP Physician)

* Preliminary Report *

Result Type:

History & Physical (IP Physician)

Result Date:

May 23, 2013 09:42

Result Status:

Unauth

Performed By: Encounter info: MD. on May 23, 2013 10:26 Inpatient, 05/23/13 -

Preliminary Report *

History & Physical

DO NOT USE PROHIBITED ABBREVIATIONS

Chief Complaint: Polytrauma

History of Present Illness: is an 8 year old male that was found in cardiopulmonary arrest by EMT after his parents called 911 reporting that he had "fell in the bath." CPR was initiated and lasted at least 15 minutes per report, the result of which is that he regained spontaneous circulation. He arrived at a blood gas was 6.96/51/156//-21. He received aggressive fluid resuscitation including 5 units of pRBCs (hgb ~4 -> hgb ~14) and 2 of FFP. He received crystallold resuscitation as well. He remained with a GCS of 3 throughout this chain of events and without spontaneous respirations. His CXR had a white out of his RUL, his head and neck CT showed a small right parietal hematoma, right tentorial subdural hematoma, questionable right parietal punctate lesion, air in the right masticator space, traumatic extraction of upper incisors, deviation of the nasal septum, no c-spine fx, and diffuse soft tissue edema circumferentially around the neck. The chest and abdominal plain fils showed opacities in the lung fields likely representing pulmonary contusion, metallic objects lodged beneath the skin thought to be beebees, and several rib fractures with callous formation. Attempts to oxygenate and ventilate him were met with difficulty. Even with spontaneous cardiovascular circulation he kept his sats in the 60's for a long time. Neurosurgery evaluated him at the OSH and determined that there was nothing to be gained from draining was transferred to for a higher level of pediatric trauma care.

Unable to obtain history - parents in police custody and child unconscious. The police arrested the parents and took the two siblings out of the house and a forensics team has already taken extensive photos of the injuries he sustained.

PHYSICAL EXAMINATION

Growth Parameters

Head Circumference:

Weight: (05/23/13 06:00) Height:

Weight Percentile: Height Percentile:

Circumference Percentile:

Vital Signs

TMAX: .

0.00 158 bpm

(05/23/13 08:31)

Heart Rate Respiratory Rate Systolic Blood Pressure

20 Breaths/Min 120 mm HG

(05/23/13 08:31) (05/23/13 08:31)

Printed by: Printed on:

MSW. 05/23/13 15:03

Page 1 of 4 (Continued)

65%

History & Physical (IP Physician)

* Preliminary Report *

Diastolic Blood Pressure 97 mm HG (05/23/13 08:31) Art. Systolic Blood Pressure 127 mm HG (05/23/13 08:31) Art. Diastolic Blood Pressure 68 mm HG (05/23/13 08:31) Arterial Line MAP 86 mm HG (05/23/13 08:31) CVP 0 mm HG (05/23/13 06:00)

General Appearance: Battered, malnourished young man intubated lying motionless HEENT: Depressed skull fracture on crown with overlying fluctuant hematoma, raccoon eyes

Neck: circumferential abrasion

Chest: Left chest rises more than right chest

Respiratory: Coarse lung sounds b/l Cardiovascular: RRR, S1 and S2

Abdomen: RIgid, nondistended abdomen, no bowel sounds

GU: uncircumcised male, foley in place rigth femoral cordis, left femoral A line.

Extremities: cool, thready pulses, injuries as below

Neurological: No spontansous movements, pupils 4 mm and fixed, no response to pain, no doll's eyes Skin: Multiple bruises, ulcers, and abrasions in various stages of healing. Several hard subcutaneous lumps which x-ray reveals to be beebees. Notable is the 4-5 cm wide circumferential abrasion on his neck, the 4 cm long laceration on his mons publis extendingdeep into the subcutaneous tissue, hardened ridged skin on right upper arm Musculoskeletal: Palpable deformities of the ribs on right lower lateral thorax, swelling and fluctuance of left hand and some of the left fingers, large fluctuance over left knee

Labs (last 24 hrs) Blood Cell Count (05/23 05:30)

RBC: 5.26 MCV: 87.6 MCH: 29.3

MPV: 9.0 **RDW-CV: 16.6** NRBC Percent: 2.5

MCHC: 33.4

Chem Panel (05/23 05:20)

	and (V2/23	05:30	,
153	109	20	/105	Ca:5.9
2.7	26	0.81		

Anion Gap: 20 Protein Total: 5.9 Albumin: 2.7

AST: 256 ALT: 155

Bilirubin: 3.2

Alk Phos: 249 Lipase Lvl: 54

05/23 05:30 **Routine Coagulation**

BG read back: Arterial Blood -

BG crit notify: BG notify D/T;

Printed by: Printed on:

MSW. 05/23/13 15:03

Page 2 of 4 (Continued)

History & Physician (IP Physician)

* Preliminary Report *

PT: 14.2 sec PT - Ref: 10.8 PT - INR: 1.4 PT 1:1: 12.1 sec PTT: 24 sec PTT - Ref: 26

Fibrinogen Level: 408 mg% D-Dimer Quantitative: >34,11

mg/L FEU

Differential Automated

Neut %: 70.3 % Lymph %: 24.6 % Mono %: 3.1 % Baso %: 0.5 % IG %: 1.5 %

Abs Neut #: 1.37 K/uL

05/23 05:47 Blood Gas BG crit action: BG crit notify: BG notify D/T: ABG Comment:
ABG pH: 7.18 Unit
ABG pCO2: 60 mm HG
ABG pCO2: 62 mm HG
ABG HCO3: 22 mEq/L
ABG TCO2: 24 mEq/L
ABG BE: -7.3 mEq/L
ABG O2 Sat: 84 %
ABG FIO2: 100 %
Whole Blood Testing

Calcium Ionized: 3.3 mg/dL Lactate, WB: 69.3 mg/dL Sodium WB: 148 mEq/L Potassium WB: 2.8 mEq/L Glucose WB: 109 mg/dL Hemoglobin POC: 16.0 g/dL Hematocrit POC: 47.0 %

05/23 08:50 Blood Gas BG crit action: BG read back: Arterial Blood ABG Comment:

ABG pH: 7.32 Unit
ABG pCO2: 33 mm HG
ABG pCO2: 240 mm HG
ABG HCO3: 17 mEq/L
ABG TCO2: 18 mEq/L
ABG BE: -7.9 mEq/L
ABG O2 Sat: 100 %
ABG FIO2: 100 %
Whole Blood Testing

Whole Blood Testing
Calcium Ionized: 2.2 mg/dL
Lactate, WB: 41.3 mg/dL
Sodium WB: 155 mEq/L
Potassium WB: 2.4 mEq/L
Glucose WB: 82 mg/dL
Hemoglobin POC: 12.4 g/dL

Hematocrit POC: 36.0 %

Preliminary Micro

None

Positive Micro (last 36 hrs)

Negative Micro (last 36 hrs) None

ASSESSMENT: is an 8 yo victim of polytrauma that suffered a cardiopulmonary arrest in the field and was resuscitated only with great difficulty and after a long period of hypoxemia and hypotension. He remains without any evidence of brainstem function but we have not yet done a brain death exam on him.

PLAN:

Neuro:

- Pending brain death exam x 2

- Attempt two regulate his chemistries better

- No sedation as he does not seem to require any and we would like to obtain a clear brain death exam

CV:

- DA gtt @ 10, titrate for MAPs 60-70

- Give crystalloid as necessar.

F/G:

- D5 NS @ NS @ 2/3 mIVF

- Replete electrolytes PRN, follow on chem 8 Q8h and gasses

- FOllow sodium closely, may start DI or cerebral salt wasting.

Printed by: . Printed on:

M\$W 05/23/13 15:03

Page 3 of 4 (Continued)



History & Physical (IP Physician)

* Preliminary Report *

Respiratory:

- Ventilating on SIMV with high pressures due to increased ab pressure and pulmonary contusion - Last settings 40/15
- Oxygenation is better on these high pressures.
- ABGs q2h, keep pH > 7.2

ID:

- Clinda ppx
- Blood cx pending

Discharge C	riteria:	
	Date of Discharge:	

Signature Line

Author(s): Physician 3rd Year - Pediatric Housestaff Co-Signer(s):

Dictated Date / Time: 05.23.13 10:26

Modified Date / Time: 05.23.13 10:26 Modified by:

- Completed Action List:
 * Perform by on May 23, 2013 10:26 on May 23, 2013 10:26 on May 23, 2013 10:27 MD * Modify by * Modify by MD. MD. * Modify by MD, on May 23, 2013 10:27
- * Sign by on May 23, 2013 10:27 Requested by 10:27 on May 23, 2013

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